

MIGRATION OF AFRICAN-TRAINED PHYSICIANS ABROAD: A CASE STUDY OF SASKATCHEWAN, CANADA

A Thesis Submitted to the College of Graduate Studies and Research
in Partial Fulfillment of the Requirements for the
Degree of Master of Arts
in the Department of Geography, University of Saskatchewan
Saskatoon, Saskatchewan, Canada

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ABSTRACT

Several factors inform health professionals' decisions to migrate from developing to developed countries to practice their profession. This study explores the "Push" and "Pull" factors that informed African-trained physicians' decisions to migrate to the province of Saskatchewan, how well they integrated into their new working environments upon arrival and how that might contribute to future migration and retention in Saskatchewan. Based on questionnaire surveys and face-to-face interviews, this study identified differences in the relative importance of precipitating factors for physicians' from South, North and "Other" African nations. Although the majority of African-trained physicians' for the study indicated that profession-related push factors were the precipitating factors for their migration, a smaller number did not cite these as important. Most respondents for the study integrated well into the health care system and have remained at their current location of practice because of the support they received from colleagues at their work places.

ACKNOWLEDGEMENTS

I have received tremendous support during the course of my studies, for which I am grateful. I am most indebted to my supervisors Drs Robert Stock and Paul Hackett for the useful suggestions, comments and financial support which helped shaped my thesis, and to Drs Evelyn Peters and Bram Noble for agreeing to serve on my committee. I appreciate the funding and opportunity offered by the Department of Geography and Planning to study here. My thanks also goes to the College of Physicians and Surgeons of Saskatchewan for providing information on the lincensed African-trained physicians in Saskatchewan and to all the respondents of the study, without whose cooperation this study would not have been complete. To my uncles, Dr. Jacob Songsore, Mr. Martin Abu and families for their support and love throughout this program. To my boyfriend, Marshall Kala, who always wanted to know how I was faring in school. To all my cousins in Saskatoon for making me feel at home throughout my studies. My studies have been very rewarding both academically and socially. Thanks to all the wonderful people I met in the course of my studies, especially Mr. Samuel M. Adaramola, formerly of the College of Engineering and my fellow graduate students.

DEDICATION

To my foster parents, who are my roots.

TABLE OF CONTENTS

PERMISSION TO USE.....	i
ABSTRACT	ii
ACKNOWLEDGEMENTS.....	iii
DEDICATION.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES	vii
LIST OF FIGURES	viii
LIST OF ABBREVIATIONS	ix
CHAPTER ONE	11
INTRODUCTION.....	11
1.1.Canadian context.....	14
1.2. Africa’s physician “brain drain”	22
1.3. Research purpose and questions.....	28
1.3.1. Research purpose	28
1.3.2. Research questions	29
1.4. Thesis outline	30
CHAPTER TWO	31
RESEARCH DESIGN AND METHODS	31
2.1. Introduction	31
2.2. Rationale for a case study approach	31
2.3. Selecting the study setting and target group.....	32
2.4. Research sample	34
2.5. Methods of data collection.....	39
2.6. Data analysis.....	41
2.7. Summary	42
CHAPTER THREE	43
AFRICAN-TRAINED PHYSICIANS’ MIGRATION TO SASKATCHEWN: SPATIAL AND DEMOGRAPHIC PATTERNS	43
3.1. Introduction	43
3.2. Addressing Saskatchewan’s physician deficit	43
3.3. From where to where: demographics of respondents.....	46
3.3.1. Countries of origin	46
3.3.2. Distribution of physicians’ by health regions	47
3.3.3. Participating physicians’ locations of practice.....	48
3.3.4 Age and gender	51
3.3.5. Year of immigration (waves and chain migration)	52
3.3.6. Medical speciality	55
3.4. Conclusion.....	56
CHAPTER FOUR.....	57
PUSH, PULL AND STAY FACTORS.....	57

4.1. Introduction	57
4.2. Defining push, pull and stay factors	57
4.3 Results and discussion	64
4.3.1. Push factors: profession-related factors in Africa	65
4.3.2. Push factors: personal and socio-environmental factors in Africa.....	69
4.3.3. Pull factors: profession-related factors in Saskatchewan.....	71
4.3.4 Pull factors: personal and socio-environmental factors in Saskatchewan	74
4.4. “Stay” factors	76
4.5. Conclusion.....	80
CHAPTER FIVE.....	81
ISSUES OF INTEGRATION	81
5.1. Introduction	81
5.3. A review of professional and social issues of integration in host nations.....	81
5.4 Results and discussion	86
5.4.1. Professional integration.....	87
5.4.2. Personal/social integration of physicians’ and their families.....	98
5.5. Conclusion.....	105
CHAPTER SIX	107
CONCLUSION, RECOMMENDATIONS, LIMITATIONS AND	
CONTRIBUTIONS.....	107
6.1. Introduction	107
6.2. Conclusion.....	107
6.3. Recommendations offered by respondents	110
6.4. Limitations & contributions.....	112
6.5. Personal Reflection	115
REFERENCES.....	120
APPENDICES	128
APPENDIX A: CONTACT LETTER.....	128
APPENDIX B: INFORMED CONSENT LETTER	130
APPENDIX C: QUESTIONNAIRE.....	131
APPENDIX D: INTERVIEW GUIDE FOR PRACTICING AFRICAN-TRAINED	
PHYSICIANS.	145
APPENDIX E: A BREAKDOWN OF DATA COLLECTION METHODS BY	
REGION OF ORIGIN AND LOCATION OF PRACTICE	147

LIST OF TABLES

Table 1.1 A typology of modes of incorporating contemporary immigrants to the advanced world.	20
Table 2.1: Number of African-trained physicians' and their locations of practice in Saskatchewan.	36
Table 3.1. Percentage distribution of African-trained physicians' by health regions	48
Table 3.2. Gender of African-trained physicians' by location of practice in Saskatchewan	54
Table 3.3. Age of African-trained physicians' by location of practice in Saskatchewan	54
Table 4.1 Endogenous and exogenous professional and socio-environmental factors for both source and recipient countries.....	58
Table 4.2. Profession-related push factors in Africa.....	66
Table 4.4. Profession-related pull factors in Saskatchewan by region of origin.....	72
Table 4.5. Socio-environmental and personal pull factors in Saskatchewan by location of practice	75
Table 4.6. Factors that would influence African-trained physicians' to stay in Saskatchewan	78
Table 5.1. Perceived importance of the medicare system by location of practice	92
Table 5.2. Perceived importance of access to hospital privileges by location of practice	93
Table 5.3. Perceived importance of opportunities for promotion or professional mobility by location of practice	95
Table 5.4. Duration of stay as a determinant to the social and physical factors physicians' found important to their initial social/personal integration.....	100
Table 5.5 Location of practice as a determinant for the social and physical factors physicians found important to their initial social/personal integration	103
Table 5.6. Region of origin as a determinant for the social and physical factors physicians' found important to their initial social/personal integration.....	104

LIST OF FIGURES

Figure 1.1 Percentage of Canadian-educated and foreign-educated physicians' by province/territory in Canada for 2004.....	18
Figure 2.1: Map showing number of African-trained physicians' for the study and their location of practice in Saskatchewan	38
Figure 3.1: Countries of origin of African-trained physicians' practicing in Saskatchewan.	49
Figure 3.2: Regional origins of African-trained physicians' by health regions	50
Figure 3.3. Year of immigration by category and location of practice in Saskatchewan	55
Figure 3.4. Medical speciality by category and location of practice	56
Figure 4.1. Factors affecting the movement of health professionals from countries of Southern Africa	63

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-deficiency Syndrome
CACMS	Committee on Accreditation of Canadian Medical Schools
CAPE	Clinician's Assessment and Professional Enhancement
CaRMS	Canadian Resident Matching Process
CIC	Citizenship and Immigration Canada
CICIMG	Canadian Information Centre for International Medical Graduates
CIHI	Canadian Institute for Health Information
CPSS	College of Physicians and Surgeons of Saskatchewan
FAIMER	Foundation for Advancement of International Medical Education and Research
FPTACHDHR	Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources
FTA	Free Trade Agreement
GATS	General Agreements on Trade in Services
GS	Government of Saskatchewan
HIV	Human Immuno Virus
IENs	Internationally Educated Nurses
IMED	International Medical Directory
IMGs	International Medical Graduates
LCME	Liaison Committee on Medical Education
MCCEE	Medical Council of Canada Evaluating Exams
NAFTA	North American Free Trade Agreement

NGS	National Geographic Society
OECD	Organization for Economic Co-operation and Development
SAPs	Structural Adjustment Programs
SIAST	Saskatchewan Institute of Applied Science and Technology
SIMGA	Saskatchewan International Medical Graduates Association
SINP	Saskatchewan Immigration Nominee Program
SMA	Saskatchewan Medical Association
SODSES	Saskatoon Open Door Society Employment Services
TOEFL	Test of English as a Foreign Language
WB	World Bank
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

African-trained physicians' migration to Canada has attracted research and media attention because of the brain drain to African countries from which physicians' obtained their medical training. The term "brain drain" is one of the consequences of migration being discussed in the literature. Interpretations vary, however brain drain may be viewed as the movement of highly skilled labour from developing to developed countries in search of opportunities that are non-existent in the home country (Gore *et al.*, 2004; Mityagiwa, 1991). Although brain drain may also be defined as the loss of skills from developing to developed countries, developed countries may experience brain drain as well. As Iredale (2000) observed, the term brain drain is not only used to explain the loss of skilled professionals from developing countries but also to describe the flow of human resources within developed countries and from poorer to higher income regions.

According to Lowell *et al.* (2001:7) "a brain drain can occur if emigration of tertiary-educated persons for permanent or long stays abroad reaches significant levels and is not offset by the "feedback" effect of remittances, technology transfer, investment or trade. Brain drain reduces economic growth through loss of return on investment in education and depletion of the source country's human capital assets". Kingma (2006) argued that the term brain drain does not capture all the dimensions of the concept. For example in source countries where health professionals are produced in excess the term brain drain would rarely be used. As mentioned, brain drain is not only observed as occurring in developing countries but developed countries as well¹.

¹ Developing and developed countries are the terms of choice consistent with the majority of the literature I have consulted in doing this study. The term Global South is also widely used, but more typically in studies within a political economy of health paradigm.

Developed countries such as the United Kingdom, Australia, Germany and Canada have suffered from similar loss of their professionals (Vidyasagar, 2006).

Canada has been both a beneficiary and a loser in the movement of educated professionals, including physicians' (Zhao *et al.*, 2000). Canada relies heavily on internationally trained health professionals; about one quarter of all medical professionals were educated internationally. Bourgeault (2007) estimated the proportion of internationally-trained health care workers in medicine to range from 6% to 8% with their total numbers continuing to increase. However, Canada has also lost a considerable number of physicians to the United States. Although the number of physicians migrating from Canada to the United States (US) has declined and some physicians' are returning, there were still 12,040 Canadian physicians' living and practicing in the US in 2006, two thirds of whom were in direct patient care (Rosser *et al.*, 2007). This study also found that Canadian educated physicians' were more likely to practice in rural areas than US-trained physicians'.

At the provincial level, Saskatchewan has been both a donor to and a recipient of health care providers from other provinces. At the same time, it has been able to attract many International Medical Graduates, especially from Africa. For example, Saskatchewan recorded a net loss of 51 physicians' in 2000 and 38 in 2004 due to migration between jurisdictions (Canadian Institute of Health Information (CIHI), 2005). On the other hand the health professionals, including physicians', leaving the province for other provinces in the country are often replaced by a similar number moving into the province from other provinces and countries (Government of Saskatchewan (GS), 2005).

There are, however, divergent views regarding the effects or impacts of brain drain. The dominant focus in the literature has been on the migration of health workers, including physicians'. This can be attributed to the negative consequences that physician "brain drain" has on source countries (Ahmad, 2004). However, some authors see the phenomenon in a more positive than negative way. Phrases like "brain circulation", "mutual gain" and "brain exchange" have been used to allude to the positive aspects of the phenomena (Gore *et al.*, 2004, Hart, 2006, Straubhaar, 2000). There have been some arguments in the literature about the positive impact of brain drain on both source and recipient countries. Beine *et al.* (2001), employing theories and models in economics, identified the positive impacts of migration on source countries as including increased access to higher education and expected higher levels of return. Developed countries are said to benefit financially and are able to fill in critical shortages in their health care system. (Eastwood *et al.*, 2005, Kline 2003)

In Canada the focus in the recruitment of physicians' has shifted from developed countries such as the United Kingdom and Ireland to developing countries like South Africa (Bourgeault, 2007). Several push factors have been cited for the drain of skilled professionals (including physicians') and various authors have given suggestions on how to stem the phenomenon (Ahmad, 2004; Stilwell *et al.*, 2004; Poole *et al.*, 2006). The interaction of market forces at the global level and government policies in developed countries has stimulated greater movement of health workers from developing to developed countries, and between provinces within Canada (Pond *et al.*, 2006; Labonte *et al.*, 2006; Chan, 2002; Dauphinee, 2005).

Language is cited as a factor determining the direction and choice of destination for health professionals. Evidence from studies of Sub-Saharan physicians' and nurses in Canada demonstrates the important role of language in determining the direction and patterns of migration of these professionals (Labonte *et al.*, 2006). For example French-speaking health professionals are mostly found in Quebec and English-speaking personnel mostly in English-speaking provinces such as Saskatchewan.

The precise magnitude of the brain drain of skilled and professional workers is unclear, due to the imprecise nature of data from both source and recipient countries (Gore *et al.*, 2004). This lack of data on the number of migrating health care workers is considered a problem not only for developing countries but also within developed countries. There are, however, limited data on the number of immigrant and emigrant health care workers in most developed countries (Buchan *et al.*, 2004).

Saskatchewan's physician "brain drain" and "brain gain" come within the dimensions of a global phenomenon described in the literature as a one way directional flow. In this case the flow is from less economically-endowed to more economically-endowed provinces within the country. However there has been little research on the phenomenon in Saskatchewan; it is an area that needs to be studied further.

1.1. Canadian context

From the Canadian perspective, multiple positions exist. One perspective, held by many in the province, sees this migration in a positive light: that IMGs can and should be utilized as a

solution to fill the shortages inherent in the Canadian medical system. Such a perspective might see the results of this study as a tool for attracting additional IMGs, or for convincing those that are here to stay, rather than move on to other jurisdictions. Another potential Canadian perspective holds a negative view of the migration because of who these migrants are. This group, perhaps far smaller than the previous, resents the use of IMGs because of issues surrounding the new arrivals', race and accents, which differ from their own. A third Canadian perspective, again probably held by a minority, is strongly opposed to this migration from the standpoint of international equity. In their view, whatever the cause of the physician deficit in the province, Saskatchewan should be responsible for solving its own physician shortage and should not "poach" from other countries, stealing already strained resources from countries that are far poorer than Canada.

The expansion of health care systems due to the aging population and coupled with a reduction of new entrants into the health workforce has been blamed for the demand in foreign health professionals in developed countries. Labonte *et al.* (2006:5) attributed the demand for foreign trained physicians' and nurses in Canada to the "demographic shifts occurring in the country, poor human resource planning, rural to urban and interprovincial drains within Canada, and regional competition for human health resources from the United States".

The medical educational system in Canada has been criticised for the shortages in the production of physicians' and the consequent demand for foreign physicians'. Chan (2002: 34-35) argued that the reduction in physician enrolment in the 1980s had a minimal effect on the decline of physician supply domestically, but that the actual decline could be attributed to longer training

requirements, the elimination of rotating internships, and the increase in the ratio of specialist to family residency positions for postgraduates entering practice from 1994-2000. Dauphinee (2005:23) pointed to the future implication of this educational trend when she stated: “the future effects of the reversal of production policies will take as long as a decade to work its way into the communities of Canada with actual practicing physicians”.

The impacts of medical education policies that have led to the current shortage of health professionals have been felt in Saskatchewan as in the rest of Canada. Saskatchewan has not been able to produce sufficient medical graduates to meet local needs, hence the need to recruit immigrant medical professionals. A Saskatchewan government document (2005) indicated that most physicians’ in the province were International Medical Graduates (IMGs). Although the document did not indicate the specific reasons for the province’s reliance on IMGs, it can be speculated that the attraction of higher pay and alternative employment for many Saskatchewan trained medical graduates in Alberta, the USA, and other places, means the province loses many of its own trained medical graduates. There is also the difficulty of recruiting medical personnel for smaller town and remote locations. Critical shortages in certain fields of specialization have also led to recruitment strategies to solve the problem. IMGs have been utilized as part of the solution to the physician shortage in the province.

IMGs are willing to work in Saskatchewan to get established in Canada even though it is a preferred destination for relatively few. Thus there has been a relatively high turnover of IMGs in the province. After practicing in the province for a while, physicians’ and especially IMGs tend to move on or do not integrate successfully into the system. According to CIHI (2007), IMGs

were more likely to engage in intra and interprovincial migration than non-IMGs. In the same report, it was noted that Ontario and British Columbia were attractive to internal migrant physicians'. In situations where Ontario or BC was not a destination choice, close neighbouring provinces were preferred. Recruitment is a constant remedy to replace medical personnel who have left for "greener pastures".

Saskatchewan relies disproportionately on developing countries for their physician supply; only 46.9% of physicians' who were active in Saskatchewan during 2004-2005 received their first medical degrees in Canada (GS, 2005). Of these, 36% received their medical degrees in Saskatchewan, and 10% were from other provinces. Physicians' who received their first medical degrees outside Canada accounted for 54% of those practicing medicine in the province, the highest in the country, followed by Newfoundland and Labrador with 41%. Quebec reported the lowest percentage of approximately 11% for foreign trained physicians' (CIHI, 2005). The report also indicated that, 26% of IMGs obtained their degrees in Africa, followed by 14% who were Asian trained.

The preceding evidence clearly shows that the expertises of IMGs including those from Africa are especially important to the province and especially in rural and underserved areas. Figure 1.1 gives a provincial breakdown of the percentage of domestic and foreign trained physicians' (including both family and specialist physicians) in 2004.

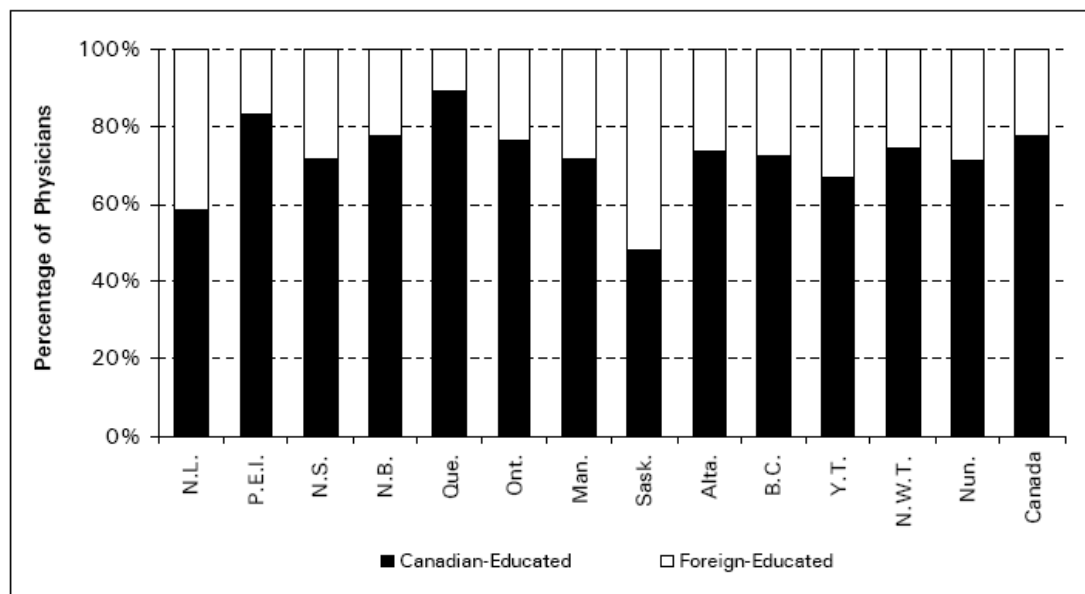


Figure 1.1 Percentage of Canadian-educated and foreign-educated physicians by province/territory in Canada for 2004

Source: Southam Medical Database. Geographic Distribution of Physicians in Canada: Beyond How Many and Where, 2005. Ottawa, CIHI, 2005, p. 27. Retrieved November 10, 2006 from: <http://www.secure.cihi.ca>

Recognising the need to fill the shortage of physicians' in the province, the government of Saskatchewan in 2005-06 implemented policies and programs aimed at recruiting and retaining physicians'. Notable among these policies and programs was an immigration policy initially targeted at physicians' but later extended to include other health professions. The province also provided four new residency seats at the University of Saskatchewan College of Medicine for internationally educated medical graduates who needed to upgrade their training before they can practice in the province. (GS, 2005)

However, the kind of selective recruitment employed to fill gaps in rural and underserved areas has attracted criticism from health human resource researchers. According to McIntosh *et al.*

(2007), government policies which aim at recruiting health professionals to underserved areas in Canada infringe on their personal autonomy, especially the right to mobility, and are in a way discriminatory since the same policies do not apply to domestically trained personnel. At the provincial level, there has been an initiative at the University of Saskatchewan to train IMGs who live in the province to specialize in anaesthesia, general surgery, internal medicine, radiology, paediatrics, psychiatry and obstetrics and gynaecology so they can provide services in the province. In turn, IMGs are bound by a one year returned service agreement to practice within the province (GS, 2005).

Whereas the factors accounting for physicians' migrating from developing to developed countries have been researched extensively, less is known about the integration of these people within the destination societies. Portes *et al.* (1989) pointed out that the diversity of contemporary migration makes it difficult to classify all migrants into a uniform path of assimilation. Table 1.1 below shows the context of incorporation and class origin. This context of incorporation and class origin accordingly shapes different settlement patterns of immigrants in developed countries.

Table 1.1 A typology of modes of incorporating contemporary immigrants to the advanced world.

CONTEXT OF RECEPTION	CLASS OF ORIGIN		
	Manual Labor	Professional-Technical	Entrepreneurial
HANDICAPPED	Secondary Market Incorporation	Ghetto Service Providers	Middleman Minorities
NEUTRAL	Mixed Labor Market Participation	Primary Market Incorporation	Mainstream Small Business
ADVANTAGED	Upward Mobility to Small Entrepreneurship	Upward Mobility to Positions of Professional and Civic Leadership	Enclave Economies

Source: Portes *et al.*: 1989

Portes *et al.* (1989) demonstrated that highly educated or skilled professionals and technical people, just as the other labour class categories, could fall into any of the three contexts of incorporation into the advanced world. There are success stories as well as stories of the difficulty immigrant physicians' face integrating into the health care system in developed countries. For this reason several countries and Canadian provinces have initiated programs to address issues on IMGs integration into their host nations and provinces. One such initiative was

the Taskforce on International Medical Graduates Licensure set up in 2004 to look into the integration and retention of IMGs in Canada.

With regard to the retention of health care professionals, Saskatchewan has not been able to retain most of its trained health care workers and continues to lose them to other provinces, although a Government of Saskatchewan health plan document in 2005 reports these losses are immediately replaced with immigrant health workers. The province is only beginning to put in place measures to absorb the unlicensed IMGs and internationally-trained nurses. Coolican (2007) reported that a significant number of nurses have difficulty obtaining licences to practice even though they are fluent in English and have higher degrees of education and experience. The same could be said for physicians.

The inability of some IMGs to practice in certain Canadian provinces has dominated the media. It is considered a loss to the countries of origin as well as to Canada. In Saskatchewan especially, there is a shortage of nurses and physicians' while the skills of unlicensed personnel cannot be harnessed and utilized. Dauphinee (2003:6) blames the unemployment of IMGs on the "disconnects" in immigration policies around landed immigrants and permanent settlers which make it difficult for some IMGs to meet the standard requirements for Canadian trainees. It is difficult for provincial and territorial health authorities to recruit and train IMGs who immigrate to Canada without prior competency assessment and job placements. The diversity of their backgrounds makes it difficult to develop a standardized certification system that effectively meets the needs of all.

The lack of licensure is not peculiar to physicians' who received their training in Africa; IMGs with training from developed countries have experienced similar difficulties trying to find employment within the health care system. For example, Mahoney reported on the frustrations a UK-trained orthopaedic surgeon had to go through trying to get certified in Ontario. Though he passed all his exams, he was still far from getting a license. This, the doctor considered "a waste of human resource when the waiting list for hip and knee replacement is a year and more". (Mahoney, 2007:A7). Educational policies may have contributed to the shortage in Canada but the disconnection in current immigration policies around immigrant physicians' hinders the ability of health authorities to absorb IMGs into the health care system.

1.2. Africa's physician "brain drain"

The movement of IMGs from Africa to Saskatchewan could also be studied from an Afro-centric perspective, from which the goal would not be to enhance the movement but instead to stem this tide. Growing up in a developing health care system in Ghana, I have witnessed long waiting hours due to the shortage of physicians. As well, the Government of Ghana has difficulty in prioritising and allocating financial resources to meet the needs and expectations of physicians who have the option of migrating abroad for better opportunities.

Although this study looks at migration from a Saskatchewan perspective, it is important to mention the impacts brain drain has on African countries. Skilled professionals frequently migrate great distances to practice their trade in countries other than their own. As Dovlo *et al.* (2004) observed, this migration of skilled professionals is not a problem except in situations where source countries lose professionals who cannot be replaced. The significant numbers of

health professionals moving from developing to developed countries is a pressing issue for governments and health human resource managers in source countries because their departure leaves the healthcare system with less staff and in some instances no personnel to manage healthcare facilities. This is reflected in a background statement of a World Health Organization report that: “The migration of skilled health workers has in the past decade become more complex, more global and of growing concern to countries that lose much-needed health workers”. (WHO, 2006:1)

Mejia (2004) suggested that the impact of physician migration be measured based on the relative need (both health care coverage and distribution) and relative loss (relationship between numbers lost and total available supply) Overall, countries with the lowest relative need tend to have the highest number of health workers compared to countries with the highest relative need. For instance, the African region has 24% of global disease burden yet has only 3% of health workers compared with the developed countries of North America (the United States and Canada) which have only 10% of global disease burden but 37% of the world’s health workers (WHO, 2006). However, Mejia (2004) observed some difficulties in measuring the extent of losses or gains of physician and nurse migration considering the diversity of variables used to measure the impacts.

The stimuli that drive migration could account for the observed patterns and the choice of destination for African health professionals. These stimuli have been accounted for through reference to push factors (unfavourable conditions that encourage out-migration) in the source country and pull factors (favourable factors that encourage in-migration) in the recipient country. Iredale (2001) also observed that accreditation issues, language and cultural factors

influenced the choice of destination for nurses. Studies undertaken concerning physician and nurse migration from Africa to the United States, the United Kingdom and Canada revealed that most of these professionals are from English-speaking countries.

Language issues as well as existing immigrant communities and kinship networks help to determine which provinces in Canada would be preferred by African-trained physicians'. Existing immigrant communities and kinship networks in recipient countries serve as a pull factor as well as defining the patterns and settlement of immigrants including physicians' (Portes *et al.*, 1989; McIntosh *et al.*, 2007). McIntosh *et al.* (2007) found that the presence of a South African migrant community and the large numbers of compatriot physicians in some western provinces, for instance, could explain the choice of those provinces for newly recruited South African trained physicians.²

The integration of health professionals is important not only for their retention within the communities in which they live and work, but also in the migration of others. According to Kingma (2006), the more people who have migrated from the source to the destination countries, the greater the communication with home countries. If this statement is reckonable, the more successfully migrant physicians' are able to integrate, the greater the quantity of positive messages sent and assistance given to their colleagues, and the more likely it is that friends and family members in their home countries or other countries will immigrate to Saskatchewan. This

² A clear example of this was a story featured in the Regina Leader-Post on January 2, 2009 about how the communities of Grenfell and Indian Head, Saskatchewan were able to collaborate and coordinate their efforts in having one physician transferred from Grenfell to Indian Head and replaced by this brother who was recruited from South Africa.

kind of feedback leads to a chain migration, where physicians' encourage friends from the same country or medical schools to immigrate to Saskatchewan.

Immigrant communities and kinship ties of physicians' not only reinforce the migration of physicians' from a particular country to Canada, and to Saskatchewan in particular, but also play an important role in the development and health care needs of their communities back home. Schiller *et al.* (1995: 2) defines migration as “the process by which immigrants forge and sustain relations that link together their societies of origin and settlement”. Some physicians have taken advantage of the opportunities and kinship networks in their countries of destination to help communities back home. Some African physicians' practicing in developed countries have used these networks and kinship ties to mobilise funds and medical supplies for their home communities. For instance, Wallace (2007) reported that, a Sudanese physician and his brothers resident in Saskatoon had saved many lives in their hometown in Sudan by donating medicine and medical supplies and providing medical care while on vacation.

According to Dovlo *et al.*, (2004), the impacts of migration on African countries are both positive and negative, and include the inability to deliver health services effectively, effects on national economies, and the effect on the individual's or household's wealth. On the positive side at the national level, international migration of health workers has been claimed to act as a welcome “safety-valve” reducing the burden on national governments of providing employment opportunities (Martineau *et al.*, 2002: 10). At the individual level, migrant health workers enjoy some benefits which otherwise would not have been enjoyed in the source country. These include

higher salaries, better and more satisfying jobs, better education for children, and more skills and opportunities for better employment upon return.

The most frequently reported negative impact of migration on African countries has been the understaffing of health systems. According to Martineau *et al.* (2002), it is problematic to measure the impact of migration on health systems because there are no personnel records to show why health professionals resign or take up appointments in the private health sector or why they start different careers. The loss of health care professionals could however be significant. For example the loss of one specialised skill may be just as significant as the greater loss of a number of general staff. The quote below is an example of how a spinal injuries centre in Boxburg near Johannesburg South Africa was closed down due to the lack of specialists.

The centre for spinal injuries in Boxburg, near Johannesburg, South Africa was the referral centre for the whole region. On the same day in 2000 the two anaesthetists were recruited by a Canadian institution opening a new Spinal Injuries Unit. The Boxburg Centre has been closed ever since. (Martineau *et al.*, 2002:10)

Migration of health professionals also impacts both negatively and positively on the educational system of African countries. Kingma (2006) reports that some educational institutions take advantage of the international demand for medical personnel not only to produce professionals for the national economy but also to serve as an “intellectual manufacturing sector” for the global market. On the other hand, migration has negative impacts on “academic reproduction”. For example the migration of Ghanaian doctors in the 1980s to the Middle East deprived medical schools of teachers. Although government initiated policies to address the situation (at the expense of staffing the health-care system), research capacity was lost (Martineau *et al.*, 2002).

One major positive impact of migration commonly cited in the literature is the benefits from remittances sent home by migrants. Both permanent and temporary migration are said to improve the balance of payments of African and other developing countries. However, as Eastwood *et al.* (2005) have argued, the idea that remittances back home could make up for deficiencies caused by migration is unrealistic especially when there is no mechanism to ensure that remittances are invested in healthcare systems.

The impact of remittances also depends on the use to which they are being put by the families who receive them. For instance, if families use money for direct consumption such as food, housing, clothing and education, it could improve their health thereby indirectly contributing to national development through increased productivity and earnings. If money received from abroad is spent on local products and services, it would stimulate further productivity, job creation and increased wages. On the other hand, Kingma (2006) suggests that the family income from remittances could lead to the over reliance of developing countries on foreign sources for income. In turn, their economies suffer when developed countries no longer need the services of foreign health professionals. Conversely, it could offset the human resource needs of health facilities because health professionals would likely stay and practice in their home countries. There is no doubt that health professionals' migration presents both benefits and challenges to the health systems of both Africa and Saskatchewan. However, as has been recommended by Labonte *et al.* (2006), there should be a concerted effort in Canada and Africa to train more health professionals and improve conditions that would retain their own trained professionals.

1.3. Research purpose and questions

1.3.1. Research purpose

As previously noted, discussions about why health care workers migrate from Africa are centered on two complementary sets of factors, one which creates unfavourable conditions in Africa and the other which serves to make developed countries more attractive. These are termed the “push” and “pull” factors respectively. Together they inform the dominant theory which has been employed to explain health workers’ migration from Africa. According to Mejia *et al.* (1979:102) push and pull factors are an “interplay of political, social, economic, legal, historical and educational” factors occurring concurrently in both source and recipient countries. In addition to exploring push and pull factors, the present study explored the stay factors (those factors that would facilitate a longer stay of physicians’) of African-trained physicians’ in Saskatchewan.

This study explores the professional and social factors triggering the movement of African-trained physicians’ and the choice of Saskatchewan as a destination. The study’s overall purpose is to illuminate the push and pull factors that helped induce African-trained physicians’ to migrate to Saskatchewan. Moreover, it is also concerned with their experiences upon arrival. Thus this study also examines their ability to integrate into their new working environments in the province, the barriers they faced in integrating and how solutions to those barriers could contribute to future migration and retention in Saskatchewan.

The study has both academic and policy implications. Academically, it will contribute to literature about the specific factors pushing physicians' from Africa and pull factors attracting them to Saskatchewan. Additionally, it will add to the scanty literature on how physicians' actually integrate into Saskatchewan. At the policy level, the study could help strengthen initiatives and programs aimed at retaining both IMGs and locally trained physicians' in Saskatchewan as per the call of Labonte *et al.* (2006) to strengthen measures that would encourage African physicians' to remain in their home countries.

1.3.2. Research questions

This study is based on direct consultation of current African-trained physicians' in Saskatchewan through both a questionnaire survey and follow-up interviews. To achieve the overall research purpose, the following research questions were considered in developing the research instruments:

1. What factors, both “push” and “pull”, have informed the decisions of African-trained physicians' to migrate to, and work in Saskatchewan?
2. How have African-trained physicians' integrated into their new working environment upon arrival?
3. How might their ability to integrate, or the barriers to integration that they face, be effectively addressed to influence their retention in Saskatchewan?³

³ There is not a unanimous support in Saskatchewan for recruiting physicians from African countries as opposed to seeking solutions internally to its physician shortage. One possibility is to address barriers around professional integration so as to influence their integration as well as absorb the non-practicing physicians in the system.

1.4. Thesis outline

This thesis is organised in six chapters. Chapter one provides an introduction to the Canadian context of physician shortage and recruitment, as well as the African physician brain drain. Chapter two focuses on the research methodology for the study. Chapter three examines the origins of the study's subjects, and location of practice in Saskatchewan. Chapter four explores the results of the study, focusing on the push and pull factors in the health care system and socio-environmental and personal reasons in both African source countries and Saskatchewan. It also touches on some stay factors (factors that influence physicians to stay in their host communities) within Saskatchewan. Chapter five presents physicians' and their families' integration in Saskatchewan. Chapter six concludes with a summary of the study's findings, implications and recommendations for retention, contributions and limitations and a personal reflection of the research process.

CHAPTER TWO

RESEARCH DESIGN AND METHODS

2.1. Introduction

This chapter focuses on the research design and methods used to explore the push-pull factors influencing the migration of African-trained physicians' and to look at how they have integrated into their new working environments. The research began with a questionnaire distributed among African-trained physicians' in the Province of Saskatchewan. This was followed up with interviews that were conducted with a sample of those practicing in urban centres, medium-sized cities and rural areas of Saskatchewan. The chapter begins with a rationale for using a case study approach, followed by a discussion regarding selecting the study setting and target groups, as well as the research sample, methods of data collection and analysis.

2.2. Rationale for a case study approach

A case study may be defined as a "systematic inquiry into an event or a set of related events which aim to describe and explain the phenomena of interest" (Bromley, 1990:302). Case studies are both processes and products of the cases being studied. The decision to employ a case study approach is not, per se, a methodological choice but in fact case studies can be studied with whatever method the researcher finds appropriate (Stake, 2003). Yin (2003) describes a case study as an appropriate strategy for addressing what, why, and how questions and contemporary issues in research.

Stake (2003:136-8) grouped case studies into intrinsic, instrumental and collective categories. A case study is considered intrinsic when a researcher wants a “better understanding of a particular case”. An instrumental case study is employed when “a particular case is examined mainly to provide insights into an issue or redraw a generalization”. A collective case study is used when a “researcher jointly studies a number of cases in order to investigate a phenomenon, population or a general condition”.

It was determined that a case study was the appropriate strategy for this study because it seeks to answer what factors inform African-trained physicians’ decisions to migrate and work in Saskatchewan and how well they integrate into their new working and social environments upon arrival. The study is instrumental in giving insights into the migration and integration of African-trained physicians’ in Saskatchewan. Little is known about this group of health care workers who represent 26% of physicians’ practicing in the province.

2.3. Selecting the study setting and target group

The research setting for the study was the province of Saskatchewan, and the target group was professionally licensed physicians’ in the province who had obtained their first medical degrees in Africa.

Professional databases provided the best available sources of obtaining statistical data on practicing physicians’ and their locations of practice. That said, professional databases only record data for professionally licensed and active physicians’; those who are unlicensed or retired are usually not captured. For example data obtained from the College of Physicians’ and

Surgeons of Saskatchewan (CPSS) in 2007 only captured physicians' who were currently licensed by the College to practice in the province. Therefore, an attempt was also made to locate a sample of non-practicing physicians' not captured in the database of the College of Physicians' and Surgeons. A snowball sampling technique was adopted for this purpose. Snowball sampling, also known as chain sampling, is defined as a non-probability sampling technique "that involves finding participants for a research project by asking existing informants to recommend others who might be interested. That is, from one or two participants, the number of people involved in the project "snowballs" (Hay, 2000:196). Berg (2001:33) describes it as the best sampling method to "locate subjects with certain attributes and characteristics necessary for a study". Although this method has some limitations, it was the most appropriate way to identify unlicensed physicians'.

In the course of asking licensed physicians' if they knew of their compatriots in the province who were unlicensed, a group of unlicensed IMGs known as the Saskatchewan International Medical Graduates Association (SIMGA) was disclosed at an orientation program organised for newly recruited physicians' by the Saskatchewan Medical Association in August of 2007. Although efforts were made to contact the African-trained physicians' of this group, only one IMG outside of the target group responded and agreed to participate in a face-to-face interview. It can only be speculated that because the stakes are so high for these IMGs trying to get licensed, the uncertainty about the survey and how it would be used, and possibly a sense of shame about their positions, could have caused the lack of interest in participating in the study. With only one participant, it was not possible to learn more about this group.

2.4. Research sample

The sampling of registered IMGs was purposive. Purposive sampling (also termed judgemental sampling) is defined as a non-probability “sampling procedure intended to obtain a particular group for a study on the basis of specific characteristics they possess. It aims to uncover information-rich phenomena/participants that shed light on issues of central importance to the study” (Hay, 2000:194). Of course this method is only useful after a researcher has clearly defined the “purpose of the study, acquired special knowledge and expertise to select subjects who represent a population” to be studied. (Berg, 2001: 32) Purposive sampling has been employed by qualitative researchers because they often “seek out groups, settings and individuals where and for whom the processes being studied are most likely to occur” (Denzin *et al.*, 2000:370).

For the purpose of this study, African-trained physicians’ are defined as physicians’ who received their first medical degrees in any African country. In Canada, they form part of a group of medical graduates referred to as International Medical Graduates, defined as “individuals who received their medical degrees from a medical school that is not accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS) or the Liaison Committee on Medical Education (LCME)” (Dauphinee, 2003:1). African-trained physicians’ for the study included both physicians’ who migrated directly from Africa and those who practiced in other developed countries before immigrating to Canada.

Information about the names, country of medical training and location of practice of African-trained physicians’ was obtained from the CPSS after ethics approval was granted for the study

from the University of Saskatchewan Behavioural Ethics Board in July of 2007. An arbitrary system of classifying communities by size was then developed for the purpose of teasing out differences by host communities. These categories were defined as urban places (populations 170,000-300,000), medium-sized cities (populations 8,000-40,000) and rural areas (populations less than 8,000), based on the 2001 Statistics Canada census report. The purpose of classifying African-trained physicians' into their communities of practice was to seek insight into whether the type of community in Saskatchewan, and the different work, social, environmental and other opportunities in the different communities were linked to their satisfaction. Other comparisons were made in relation to demographic characteristics of African-trained physicians' in the sample, especially their gender, age and region of origin.

African-trained physicians' were also put into three categories based on their region of origin, which are South Africa, North Africa and "Other" Africa (including West, East, Southern and Central Africa). These categories were arrived at because the South African group is particularly unique because of the comparatively large number of physicians' in Saskatchewan and their medical training which is considered among the best in the world. The large number of physicians' also suggests a good network of South Africans who could help newly recruited physicians' to integrate into the health care system better than others. The North African group is also unique because countries such as Morocco, Libya, Algeria and Egypt are relatively developed compared to other African countries. This category also includes a sufficient number of physicians to form a separate category. The rest of Africa includes countries from Southern, Central, West and East Africa. Physicians' from these regions altogether formed a substantial number. It was expected that with the break down of location of practice, these physicians' would

have different experiences integrating into the health care system and society. Also, the different racial makeup of these three groups especially the primarily white South Africans, the Egyptian-Arabs and Berbers from North Africa, and black Africans coming from other African countries could point to the differences in their experiences and degree of integration into Saskatchewan.

Data compiled from the CPSS showed that there were 483 African-trained physicians’ practicing in Saskatchewan in 2007. Of the 483 African-trained physicians’, 360 came from South Africa, 57 from North Africa and 66 from the “Other” Africa. Of these 483 physicians’, 178, 170 and 135 were practicing in urban, medium-sized and rural areas respectively. Table 2.1 summarizes regions of origin and location of practice.

Table 2.1: Number of African-trained physicians’ and their locations of practice in Saskatchewan.

Region of Origin	Total number of African-trained physician in Sask	Location		
		Urban	Medium	Rural
South	360	108	129	123
North	57	32	23	2
Other	66	38	18	10
Total	483	178	170	135

Source: CPSS, 2007.

The data provided from the CPSS also included year of license, surname, given name, clinic name, street address, community, province, country, postal code and country of medical degree. Names and contact information was used to map out the sampling technique. Using a Sasktel online phone directory, phone numbers were obtained for those who had enlisted their phone numbers in the directory and were contacted by phone to ask for their consent to participate in the study. A questionnaire was then mailed out or faxed to them once they consented to participate on phone. For those who still requested to know more about the study before they consented, addresses were verified or fax numbers obtained and consent form was mailed or faxed to them. For those whose phone numbers could not be obtained, letters were written to the addresses provided by the CPSS.

A total of 124 physicians' with valid addresses from the CPSS and phone numbers from the Sasktel online phone directory were contacted in writing and through phone calls or by fax to seek their consent to participate in the study. A total of 44 physicians' consented to participate and 44 questionnaires were mailed or in some cases faxed to them. Of the 44 questionnaires mailed or faxed to respondents, 33 questionnaires were returned, 15 from urban practitioners, 12 from medium-sized cities and 6 from rural practitioners (see appendices for the questionnaire and interview guide). ⁴ Figure 2.1 below is a map showing the distribution of the 33 physicians' who participated in the phase of the study.

⁴ Given that physicians are extremely busy people, the response rate was quite encouraging

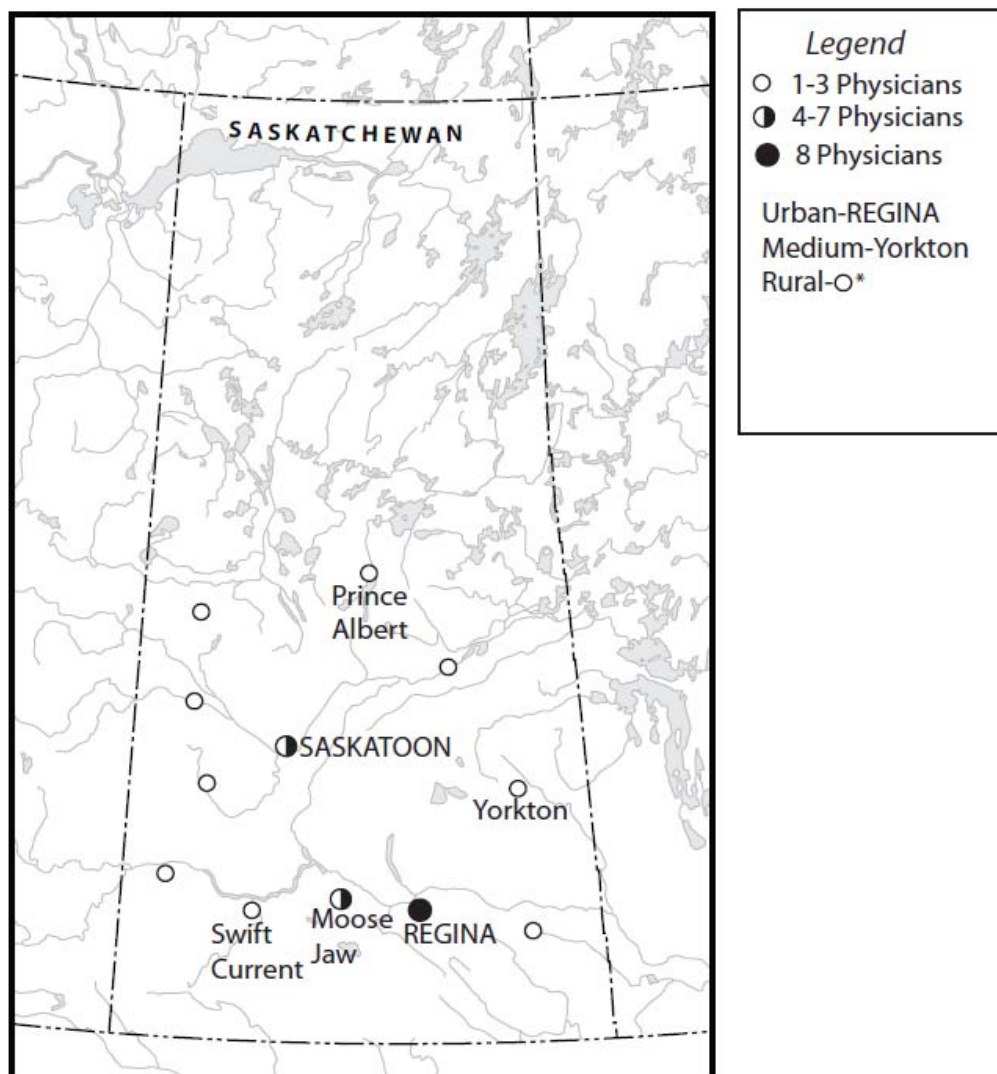


Figure 2.1: Map showing number of African-trained physicians for the study and their location of practice in Saskatchewan
Source of Data: CPSS, 2007.

Seventeen physicians' consented to do follow-up interviews. A total of 11 interviews were conducted, including 3 face-to-face interviews with physicians' in urban areas and the other 8

were phone interviews with one physician in an urban area and the others in rural and medium-sized cities in Saskatchewan. Although Berg (2001) recognised some flaws with using phone interviewing such as a lack of face-to-face non-verbal cues which determine the pace and direction of the interview, he justified its use in instances where the researcher intends to reach a sample population in geographically diverse locations. Because African-trained physicians' are located in diverse locations across the province and because the cost and time to visit physicians' at their places of work across the province would have been prohibitive, phone interviewing had to be used to gather data.

2.5. Methods of data collection

The literature presents varied reasons why people migrate. Most often these are presented quantitatively, which fails to capture nuances and the passion behind individual decisions to migrate. Quantitative research is also limited by the quality of available data. National databases and professional databases are sources which may not be as complete as one would like. According to Mejia (2004), these sources often are not rigorously maintained, especially in developing countries. Another issue is the lack of standard operational definitions; composite estimates from a variety of sources make it difficult to compare data at the international level. Because of these limitations, there is a need for more qualitative research on physician migration.

Data for the study were gathered from an open and closed-ended questionnaire and face-to-face and phone interviews using a semi-structured interview guide. Interviews were scheduled and conducted by phone for physicians' outside Saskatoon and Regina. For those who opted for a face-to-face interview, interviews were scheduled and conducted in an environment that was

convenient and comfortable for them. With the permission of interviewees, all interviews were audio taped and later transcribed.

The semi-structured questionnaire was divided into three sections (see Appendix A). The first section focused on physicians' biographical information, with a sub-section on their medical background and medical specialization. The second section looked at push-pull factors and migration within Saskatchewan after arrival. Physicians' were invited to select from a list of push-pull factors; the primary factors (most important) and secondary factors (others) influencing their decision to migrate. These push-pull factors were informed by the work of Padarath et al (2003) who categories them into health care, personal and socio-environment factor for both source and destination countries. The third section focused on issues of integration looking at the first two years of both professional and social integration and their long-term integration and future migration plans. Physicians' also had the opportunity to provide their own comments on these issues, the purpose of which was to elicit as much case-specific information as possible and to allow them to share their opinions about issues and the passions behind their migration decisions. Individual stories obtained from comments on returned questionnaires and through personal interviews provide a more nuanced understanding of migration decisions than categorical data from questionnaire surveys. Physicians' are busy people and it was anticipated that most of them were not going to consent to a follow-up interview.

Face-to-face and phone interviews were used to give physicians' the opportunity to tell their stories in more detail and in their own words. They also allowed the researcher to clarify some questions that respondents thought were ambiguous. Open-ended questions were used to explore

in more detail the factors that informed their migration decisions and to learn about how they integrated into their work environment upon arrival. A semi-standardized interview schedule was used during the interviews. Berg (2001) recommended a semi-standardized interview because it gives the interviewer some flexibility with asking prepared as well as standardized questions. A semi-standardized interview structure helped to clarify and confirm responses on the questionnaire survey. These interviews generated qualitative data that using only a questionnaire survey could not have readily provided.

2.6. Data analysis

According to Yin (2003:109) the process of data analysis in a case study consists of a series of steps “examining, categorizing, tabulating, testing or otherwise recombining qualitative and quantitative evidence to address the initial propositions of a study”. During the data analysis, questionnaire data were examined, categorized and cross tabulated. Narratives from the individual face-to-face and phone interviews with physicians were transcribed and insightful quotations were highlighted. Both qualitative and quantitative evidence were then combined to address the study’s primary research questions. Qualitative data was used to buttress the quantitative data because they provide in-depth insights into the study.

The sample size for the study was too small to require the use of any quantitative computer assisted software or to enable the use of inferential statistical methods. The data were tabulated manually and presented in simple cross tabulations and bar charts because the sample size was too small to support any rigorous statistical analysis. Although not conclusive, patterns that have emerged in this study are suggestive of the attributes and attitudes of African-trained physicians’.

Qualitative analysis, based on the narratives of respondents, was also done manually and contributed to a better understanding of the quantitative data. Some of the narratives required minor editing to remove inappropriate language and grammatical errors so it could be presented in a manner that was readable and understandable. The use of physicians' actual words served to convey their thinking and the passion behind them. Narrative evidence was incorporated within the thesis and has provided rich insights into physicians' own perspectives of issues around their migration and integration into Saskatchewan.

2.7. Summary

This case study employed questionnaire surveys and follow-up interviews to study the motivations behind the migration of African-trained physicians', and issues related to their integration in Saskatchewan. Both qualitative and quantitative methods of questionnaire surveys and follow-up interviews were employed to gather primary data. Sampling for the study was targeted at licensed African-trained physicians' living and practicing in Saskatchewan. Information on practicing African-trained physicians' was obtained from the CPSS. Quantitative data from questionnaires were manually analysed and presented with graphs and cross tabulations. Narratives from follow-up interviews were incorporated into the thesis.

CHAPTER THREE

AFRICAN-TRAINED PHYSICIANS' MIGRATION TO SASKATCHEWN: SPATIAL AND DEMOGRAPHIC PATTERNS

3.1. Introduction

This chapter begins with a brief discussion of the causes, implications and solutions sought for the physician deficit in Canada and Saskatchewan. The origins, destinations and demographic characteristics (gender and age, year of immigration (waves and chain migration) and medical speciality) of African-trained physicians' in Saskatchewan are also discussed. The number of physicians' from African countries and their destination communities in Saskatchewan are presented cartographically.

3.2. Addressing Saskatchewan's physician deficit

The global health worker shortage is triggering the movement of health professionals from Africa to work in developed countries. Labonte *et al.* (2006) attribute the demand for foreign trained physicians' and nurses in Canada to a combination of factors, including demographic shifts, poor human resource planning, rural to urban and interprovincial drains and regional competition for human health resources from the United States. The out-migration of physicians' is a major factor in Saskatchewan's physician shortage, especially in rural areas of the province. Also, the deficit in particular specializations in the province creates the need to recruit physicians' from other countries. The net implication of these factors is a continuing reliance on foreign trained health care professionals, and such reliance is likely to continue long into the future (Dauphinee 2005:23).

One of the approaches that the Province of Saskatchewan has taken to solve the physician shortage is the implementation of specific policies and agreements to attract skilled labour to meet the short term demands for health care workers. Two such policies, the Provincial Nominee Programme and the Immigration Point System, were identified by Labonte *et al.* (2006) as policies that are targeted at foreign-trained health professionals. Saskatchewan was a signatory to the Provincial Nominee Programme in 2002. The five year agreement was intended to attract 200 skilled workers to contribute to the socio-economic development of the province (Citizenship and Immigration Canada (CIC), 2002). To implement this policy, Saskatchewan entered into partnerships with health regions to include in the Saskatchewan Immigration Nominee Program (SINP) a category for international health professionals. The SINP started off with offering landed immigrant status to IMGs practicing with a temporary license in 2002 and extended the policy to nurses in 2003 (GS, 2005).

Health professionals respond to the demand for their services through what Bach (2006:14) termed “formalised channels of recruitment”, which includes commercial recruitment agencies and the internet. Overseas professional associations and other support networks play an important role in the mobility of health workers which, according to Bach, is overlooked in the analysis of these migrations. He argued that the role that recruitment agencies play differ according to occupation and country. For instance recruitment agencies play a limited role in the recruitment of physicians’ to the United Kingdom because of the central role played by the Department of Health in the recruitment process.

Unlike a more centralised system of recruitment in the United Kingdom, in Canada there are a number of insider and outsider formal or informal recruitment channels for health care professionals from Africa. These include regional health authorities, private practice clinics, recruiters based in Sub-Saharan Africa, and individual recruiters in Canada. Labonte *et al.* (2006) found that recruitment agencies in Canada tended to recruit passively, and that they formed a small proportion of formal agencies engaged in the recruitment of African-trained physicians'. Some of these agencies are said to be partially or entirely government funded, while others are non-profit organizations. They recruit physicians mainly to fill vacancies in rural areas, and focus primarily on the recruitment of professionals in Canada. At the same time, foreign trained health workers have access to these advertisements on the internet.

The study by Labonte *et al.* (2006) revealed that most Sub-Saharan trained physicians' who emigrated to Canada and Saskatchewan were encouraged by friends, colleagues and former classmates who gave information about opportunities and facilitated their immigration to Canada and Saskatchewan. They also found out that, spouses of foreign trained health workers sometimes acted as contacts and recruiters. McIntosh *et al.* (2007:2) also observed from anecdotal evidence that recruitment of physicians to some provinces in Canada was through "word of mouth". Individuals already integrated and settled in Canada have served as a major channel of recruitment for recent immigrants to Canada.

Advertisements in local papers, professional journals, and job fairs, have been used in recruitment efforts from developing countries. According to Dovlo *et al.* (2004) active recruitment of x-ray technicians and radiographers in Ghana, Kenya, South Africa, Uganda and

Zambia had taken place through such channels. Saskatchewan's recruitment efforts have involved all of the above strategies. Word of mouth was also shown to be very important in this study.

3.3. From where to where: demographics of respondents

3.3.1. Countries of origin

Figure 3.1 below shows that the majority of African-trained physicians' in Saskatchewan come from South Africa, followed by countries from Western, Southern, Eastern and Central Africa (Ghana, Nigeria, Kenya, Sudan, Zambia, Zimbabwe, Uganda, and the Democratic Republic of Congo). Missing in this category is the majority of countries in Africa, including such large countries as Ethiopia and Senegal.

The pattern found in this study corresponds to that reported by Labonte *et al.* (2006). They found that six African countries serve as principal sources of physicians' coming to Canada, namely South Africa, Sudan, Zambia, Zimbabwe, Ghana, Uganda and Nigeria. What these countries have in common is English as one of the official languages, which gives these migrants a natural advantage over their Francophone counterparts. It could also be speculated that these countries have a higher turn out of physicians' than most other African nations. Other factors may be involved, such as in South Africa where political uncertainty, the erosion of white privileges and concerns about security following the end of apartheid led to the large exodus of white South African professionals abroad. (Mattes *et al.*, 2000)

3.3.2. Distribution of physicians by health regions

The highest percentage of African-trained physicians' of total physicians' was found in the Heartland Health Region (87%) followed closely by Sunrise Health Region (71%) (Table 3.1). This finding raises questions as to the extent Saskatchewan relies on African-trained physicians' to provide basic health care in rural health regions. Again, depending where physicians' came from or would have practiced, they may be content with rural practice. Regina Qu'Appelle region, a largely urbanized health region, recorded the second lowest percentage but highest in absolute numbers. It is surprising, though, that Regina has more African-trained physicians' than Saskatoon considering the presence of a teaching hospital in Saskatoon. The concentration of African-trained physicians' in health regions outside of the major cities and town, could also point to the fact that urban Saskatchewan provides an attractive environment for Canadian-trained personnel to practice.

The proportion of African-trained physicians' by health regions is shown in Figure 3.2 below. African-trained physicians' are located in all health regions of Saskatchewan, and the South African group constitutes a significant percentage of physicians' in all the health regions. For example within the Regina Qu'Appelle health region, 79 out of 121 African physicians' (65%) were South African trained, followed by North African (22 of 121, or 17%) and those from "Other" African countries (20, or 18%). For the Saskatoon region, there were 55 South Africans, representing 63% of all African practitioners in the region.

Table 3.1. Percentage distribution of African-trained physicians by health regions

Health regions	All Physicians	African Physicians	% African
Prince Albert & Mamawetan Churchill River	119	58	49
Prairie North & Keewatin Yatthe	99	58	59
Saskatoon	773	87	11
Sunrise	48	34	71
Cypress	47	23	49
Five Hills	57	40	70
Regina Qu'Appelle	480	121	25
Sun Country	41	22	54
Kelsey Trail	33	20	61
Heartland	23	20	87
Total (%)	1720	483	28

Source: College of Physicians and Surgeons of Saskatchewan, 2008

3.3.3. Participating physicians' locations of practice.

Respondents to the survey were practicing in big as well as small communities of the province. Fifteen (46%) came from Regina (population 179,246) and Saskatoon (202,340); 12 (36%) were practicing in medium-sized cities such as Prince Albert (34,138), Moose Jaw (32,132), Swift Current (14,946) and Yorkton (15,038), and 6 (18%) were practicing in smaller communities. (refer to Figure 2.1 for the spatial distribution). The number of participants was not entirely representative of the distribution of the population of African-trained physicians'. For example, there were no participants from Northern Saskatchewan. A higher number of physicians' from urban and medium-sized cities participating in the study could be explained in part that higher

numbers of African-trained physicians' were located in urban and medium-sized cities of Saskatchewan than rural, hence providing a large sample to draw on.

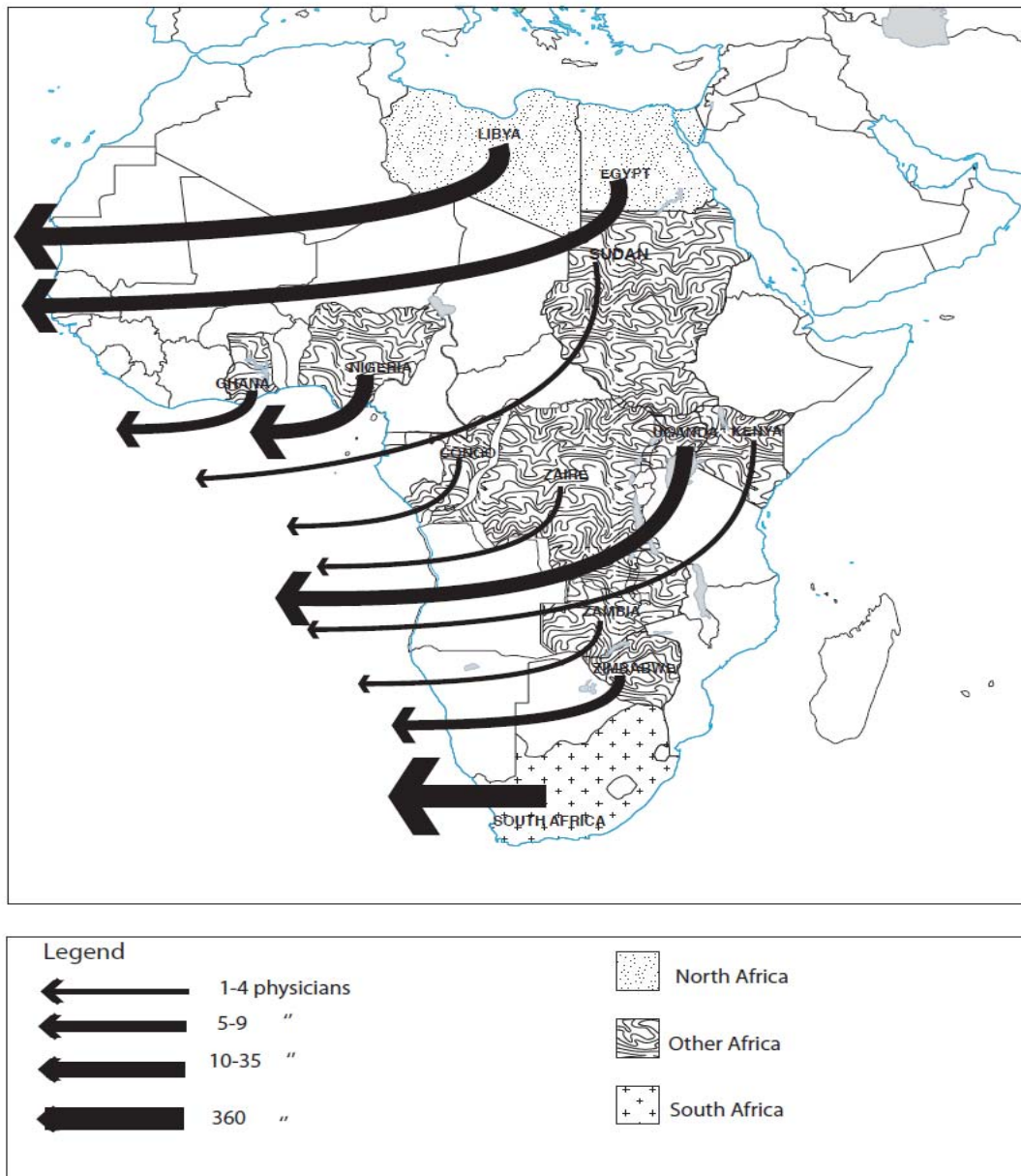


Figure 3.1: Countries of origin of African-trained physicians' practicing in Saskatchewan. Data source: CPSS, 2007.

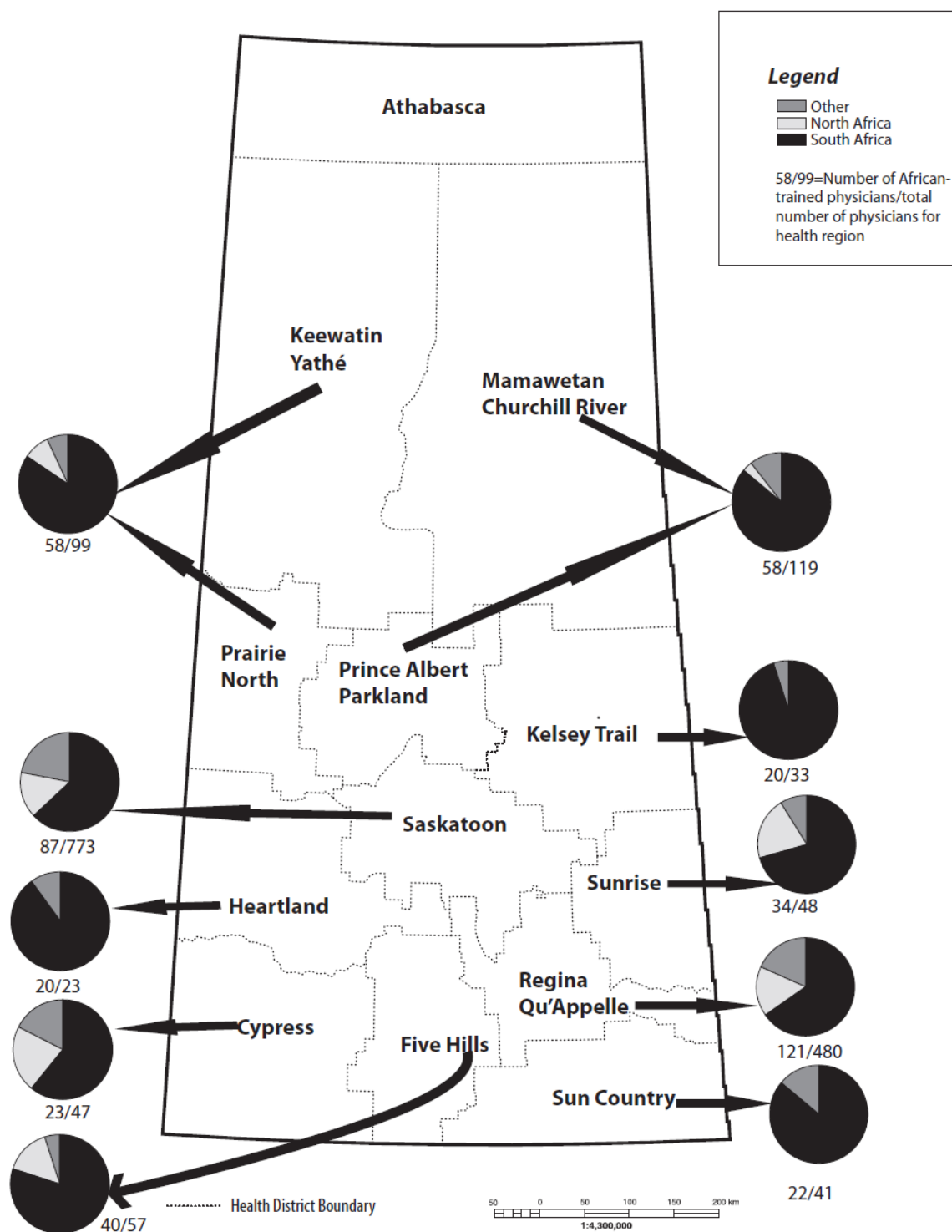


Figure 3.2: Regional origins of African-trained physicians' by health regions
Source of Data: CPSS, 2007

3.3.4 Age and gender

According to a study by Boyd *et al.* (2007) based on the 2001 census data, all International Medical Graduates (IMGs) arriving in Canada were aged 28 or older, with the majority aged 32-54. A Government of Saskatchewan Workforce Action Plan (2005) reported that, as of 2004-2005, 29% of active physicians' were 55 years or older and 71% were younger than 55 years. (This figure included both Canadian and foreign-trained physicians).

Most respondents for the study were relatively young. Tables 3.1 and 3.2 below show the gender and age of physicians' by location of practice. There was a relatively higher percentage of physicians' in the older (45+ years) age category who were practicing in urban areas. The relatively older physicians' in urban areas might be due to migration and relocation processes over time of physicians' following their arrival in the province. When physicians' first come they often start off in smaller communities and with time many move to urban areas. Younger cohorts were generally found in medium-sized cities and rural areas.

Han *et al.* (2006), researching the integration and retention of international medical graduates in rural Victoria, Australia, estimated that 37 (65%) were male and 20 (35%) were female. There are generally more male than female IMGs. Although it was sometimes difficult to tell by name if a physician was male or female from the data gathered from the CPSS, names allowed for the classification of most respondents. Overall, there were 25 (76%) male and only 8 (24%) female respondents for the study.

3.3.5. Year of immigration (waves and chain migration)

Research by Boyd *et al.* (2007) has demonstrated that physicians' birthplace and year of immigration to Canada has an impact on their chances of being employed in a health occupation. They found that physicians' born in Africa had an 85% chance of being employed in a health occupation compared to only a 63% for their counterparts from West Asia. Physicians' who immigrated to Canada before the 1980s had a 95% chance of being employed in a health occupation compared to 70% for those who immigrated from 1991-1996. Their observations raise questions about the role the predominance of physicians' from certain countries (e.g. South Africa) could play in the chain migration to certain provinces. Language issues or possibly an element of discrimination in recruitment could also help to explain the observed pattern of the current study. Finally, it raises the question as to whether physicians' who came before 1980 were better trained or whether those who were unable to become registered have moved to different provinces or countries.

Obviously, the year of immigration and duration of stay in Saskatchewan plays an important role in how well physicians' integrate into their work place and communities of residence. Physicians' in this study who have lived in Saskatchewan since the 1980s and 1990s were more likely to encourage family members and friends back home to migrate to Saskatchewan than those who had immigrated more recently. Figure 3.3. show the year of immigration by category and location of practice.

From Figure 3.3 below, the earliest African-trained physicians' in the study, now practicing in urban Saskatchewan, migrated to Saskatchewan between 1960 and 1969. However no African-trained physicians' included in the study migrated during 1970-1979 period. A small number of African-trained physicians' in the sample arrived in the 1980s, with the pace increasing in the 1990s (4 out of 6 were South African). The majority of respondents migrated to the province in the period 2000-2007.⁵ This finding is consistent with the finding of Labonte *et al.* (2006) in their study of immigrant health care professionals from Sub-Saharan Africa to Canada. In their study, they found that the flow of health professional from Sub-Saharan Africa had been increasing since the early 1990s. They also found that South African trained physicians' tended to settle in places where they were close to well-established classmates, friend and colleagues. Given this, Figure 3.3. suggests the possibility of a chain migration of South and North African trained physicians' to urban, medium-sized cities and rural Saskatchewan. Seven (100%) respondents from "Other" Africa who were recruited in 2000 and 2007 from the United Kingdom to medium-sized cities of Saskatchewan indicated that friends and colleagues well-established in Saskatchewan had helped with providing information on job opportunities while they were in the United Kingdom. This finding is also consistent with the development of a chain migration process.

⁵ The pace of emigration from South Africa has increased since the end of Apartheid reflecting some apprehension among white South Africans about the future prospects in the country's new political realities.

Table 3.2. Gender of African-trained physicians' by location of practice in Saskatchewan

Gender N (%)*	Female	Male	All
Location of Practice			
Urban	4 (26)	11 (73)	15 (45)
Medium	1 (8)	11 (92)	12 (36)
Rural	3 (50)	3 (50)	6 (18)
All	8 (24)	25 (76)	33 (100)

*Number of responses (Percentage)

Table 3.3. Age of African-trained physicians' by location of practice in Saskatchewan

Age	<30	30-44	45+	All
Location of Practice				
Urban	0 (00)	7 (47)	8 (53)	15 (45)
Medium	2 (17)	6 (50)	4 (33)	12 (36)
Rural	2 (33)	3 (50)	1 (17)	6 (18)
All	4 (12)	16 (48)	13 (39)	33 (99)

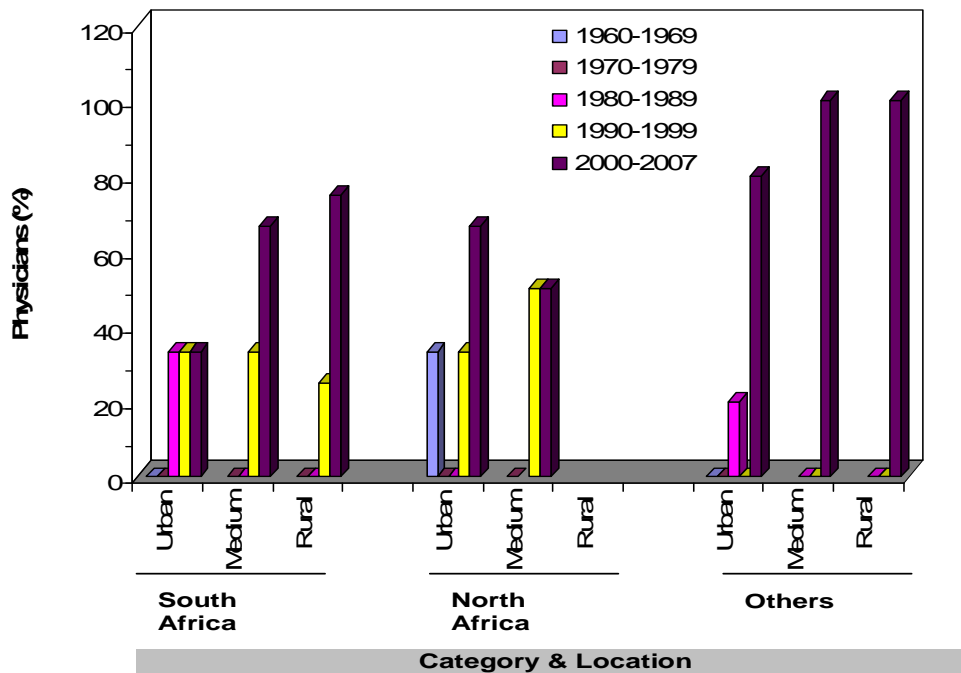


Figure 3.3. Year of immigration by category and location of practice in Saskatchewan

3.3.6. Medical speciality

Nationally, there has been an increase in the number of IMG family physicians' practicing in Canada from 59,412 in 2002 to 62,307 in 2006. Within the same period, the number of IMG specialists decreased slightly from 6,659 to 6,374. Provincially, there were 466 family physicians' and 281 specialist IMGs in Saskatchewan (CIHI, 2007).

In Figure 3.4 below, participants in the study were divided between 15 (45%) family physicians' and 18 (55%) specialists, and further broken down by region of origin and size of the community of practice. The "Other" Africa category had 5 (71%) specialists practicing in medium-sized cities compared to 2 (33%) specialists in medium-sized cities from South Africa. The South African category had only 4 (100%) family physicians' practicing in rural areas while the North

African category had no physicians' practicing in rural Saskatchewan. Again, the sample size is too small to make inferences about how representative these patterns are for the entire population.

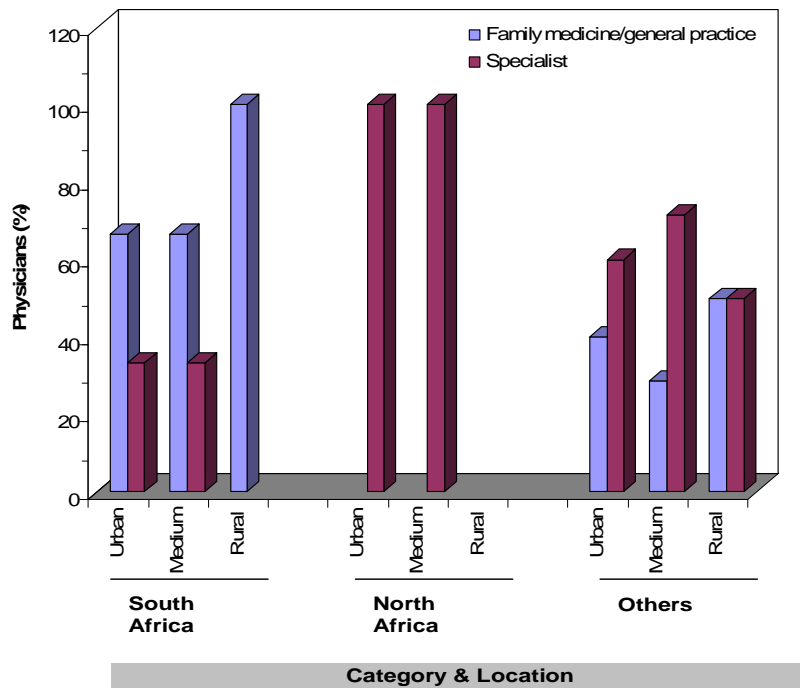


Figure 3.4. Medical speciality by category and location of practice

3.4. Conclusion

Participants for the study in medium-sized cities and rural areas were relatively younger than those in urban centres. The year of immigration and duration of stay played a significant role in the level of integration in the health care system and communities of Saskatchewan. As well, physicians' who had stayed in Saskatchewan longer were more likely to have encouraged and supported friends and family members to immigrate to Saskatchewan. The study also confirmed findings from other studies that the majority of IMGs to the province were South African-trained. South African-trained physicians' were not limited to certain areas but were located in all ten health regions of the province.

CHAPTER FOUR

PUSH, PULL AND STAY FACTORS

4.1. Introduction

This chapter presents survey results and, in the physicians' own words, the motivating factors for leaving their home countries to practice in Saskatchewan. It explores the interaction of professional, socio-cultural and environmental push-pull and stay factors in physicians' countries of origin and in Saskatchewan.

4.2. Defining push, pull and stay factors

In the context of international physician migration, push factors have been defined as factors in the source countries (countries of origin) that encourage health professionals to migrate, while pull factors are those factors that serve to make the recipient countries more attractive to health workers (Padarath *et al.*, 2003). Push and pull factors generally go together because one cannot exist without the other. The decision to migrate from a source country is always influenced by attractions in the destination country. As such it buttresses Mejia *et al.*'s. (1979) view that push and pull factors compliment each other.

Several authors (Mejia, 1979; Martineau *et al.*, 2002; Bach, 2003; Dovlo *et al.*, 2004; Eastwood *et al.*, 2005; Labonte *et al.*, 2006) have focused on similar push-pull factors in different wordings. The classification presented by Padarath *et al.* (2003), in their study of health personnel in Southern Africa is unique in its approach to unequal distribution of health personnel and brain drain in that region. They separated push-pull factors into professional and socio-environmental

push-pull factors in both source and recipient countries in what they referred to as endogenous and exogenous push and pull factors. Endogenous factors are directly related to professional practice in both source and recipient countries. As such they can encompass both push and pull factors. Conversely, exogenous factors are those socio-environmental factors operating in both source and recipient countries. This mode of classification clearly distinguishes profession-related and socio-cultural factors influencing physician migration, which could give health administrators and stakeholders a starting point in curbing the health human resource flight. Table 4.1. provides examples of endogenous and exogenous factors in both source and recipient countries.

Table 4.1 Endogenous and exogenous professional and socio-environmental factors for both source and recipient countries

Endogenous (Professional) push factors	Endogenous (Professional) pull factors
<ul style="list-style-type: none"> • Remuneration and salaries • Lack of job satisfaction • Work associated risk • Lack of further education and career development opportunities 	<ul style="list-style-type: none"> • Higher rates of remuneration • More satisfying work conditions • A safer working environment • Better educational and career development opportunities
Exogenous (socio-environmental) push factors	Exogenous (socio-environmental) pull factors
<ul style="list-style-type: none"> • Quality of life and crime, war, civil conflict and political repression • Lack of educational opportunities for children 	<ul style="list-style-type: none"> • Higher quality of life • Freedom from political persecution, speech and educational opportunities for children

Source of factors: Padarath *et al.*, 2003. 11-13

For the health professional, environmental as well as individual considerations are factors contributing to the decision to migrate. Martineau *et al.*, (2002) classified the factors which led to

migration as operating on four levels, namely international, national, individual and the employer. Dovlo *et al.*, (2004:11-12) not only identified what push-pull factors influence health professionals' migration from Africa, but also classified them in relation to different gradients in both source and recipient countries. Examples of these push-pull gradients included income (or remuneration), where the difference in income and work conditions is often compared with those associated with the target country; job satisfaction (perceptions of good working conditions and the optimum utilization of technical and professional skills); organizational environment/career opportunities (opportunities for professional development and a well managed health care system); governance (political governance, differences in administrative bureaucracy and the efficiency and fairness with which the broader governmental services are managed); and protection, risk and social benefits (differences in risk, such as the probability of exposure to HIV/AIDS in Africa due to the lack of protective gear) compared with recipient countries. At the base of the model is the social and security gradient (concern about security after retirement). The above classification enforces Mejia's argument that the interplay of push-pull factors causes the movement of professionals.

Eastwood *et al.*, (2005), in their study of the migration of health professionals from Sub-Saharan Africa to the United States, found that the lack of opportunities for further training, underfunding of health care facilities, poor retirement packages, government and health service management shortcomings, civil unrest and lack of personal security were factors that drove health professionals to the United States. In a similar vein, Labonte *et al.*, (2006) grouped the above-mentioned push and pull factors into working conditions, job security, economic and political considerations, physical security, quality of life and job security (the lack of available

jobs, lack of opportunities for promotion and risk of job loss due to a lack of funds). Another stimulus for physician migration is the supply and demand of physicians caused by market forces and government policies at both the international and domestic levels. For example, in a study of four OECD countries, Pond *et al.*, (2006) demonstrated how health resource labour markets and government policies shape the supply and demand of health professionals for those countries. Demand and supply of health professionals have been viewed in the context of the international labour market. Some health qualifications accordingly have become common across countries, or in other words “internationalised”, so that the training of health professionals takes into account the standards and demands of the international labour market to meet international labour market shortages (Dovlo *et al.*, 2004, Iredale, 2001).

The increasing rates of health problems, especially non-infectious diseases, have particularly brought an increased need for health workers and resources in Africa. However, African countries have had difficulty retaining, attracting or obtaining these health-sector workers (Dovlo *et al.*, 2004). Economic resources determine the number of physicians’ and nurses that most African countries can employ to provide needed health services. Most African countries cannot afford to employ the manpower needed to provide basic health services because of their limited financial resources. This has resulted in the out flow of health workers from the continent (Mejia, 1979). As well, Structural Adjustment Programs (SAPs) in the 1980s led to cuts in government spending on social services and commercialization of state owned companies in most African countries (Sanders *et al.*, 1991).

The literature on health worker migration indicates that similar push-pull factors occur in developed countries. For example, the movement of Canadian health professionals to the United States has been attributed to higher tax rates and a comparatively low wage paid to health workers in Canada as against higher wages paid in US dollars and better employment opportunities resulting in a lower unemployment rate in the US compared with Canada. Greater exposure to leading edge technology, lower taxes, better management and warmer climate are other factors influencing migration patterns (Iqbal, 1999, Taylor, 1999).

International and national trade agreements have helped to facilitate skilled labour migration. These agreements have policy implications and can be detrimental to both developed and developing countries. Such international policies have not only facilitated the movement of skilled labour from developing countries but also migration between developed countries. For example, national policies and international trade agreements, such as General Agreements on Trades in Services (GATS), and Free Trade Agreements (FTA) such as the North American Free Trade Agreement (NAFTA), have contributed to the migration both from Canada to the United States and from developing to developed countries. These policies and agreements will continue to stimulate migration in the future (Eastwood *et al.*, 2005, Iqbal, 1999).

Another key stimulus discussed in the literature is the culture of migration in some sub-regions of Africa. A study focusing on the views of African-trained physicians' and implications for policy by Hagopian *et al.* (2005) revealed the culture of migration in medical schools in Nigeria and Ghana. Faculty members with experience practicing abroad served as role models and in fact encouraged their students to gain some experience abroad. This is one unique study which gave

more prominence to the culture of migration and reveals the passions and views of medical students and faculty members of medical schools in Ghana and Nigeria. However, it is not clear that the cultural factors identified in this study can explain the pattern of migration in other parts of Africa.

The above push and pull factors influencing migration decisions have been criticised for their inability to account for differences in the patterns of migration and for reasons why some people migrate and others stay (Portes *et al.*, 1989). In fact, other types of factors are also influencing the decision-making process. Padarath *et al.* (2003), in addition to discussing push-pull factors, also identified both “stick” and “stay” factors affecting health professionals migration. According to them the “stick” factors are those that health professionals have to overcome before deciding to migrate. These include high level morale, rewards and incentives outside the work system, and social and kinship ties. Other factors such as the cost of re-qualification and relocation, the need to learn a new language, different clinical practices, and time consuming immigration procedures may also be barriers to migration. The “stay” factors are those that make health workers decide to stay permanently in their recipient countries. Some of these were identified as development of new social and cultural bonds in the destination country, the risk of disruption to family life and education of children, and new lifestyle patterns (Dovlo *et al.*, 2004, citing Padarath *et al.*, 2003). Ngunjiri (2001), citing an International Organization for Migration report, reiterated the lack of information on job opportunities in their countries of origin as a reason many African-trained professionals remain in their host nations abroad.

Figure 4.1 below is a schema of “push-pull”, “stick” and “stay” factors adapted from Dovlo *et al.*, (2004:13) and originally developed by Padarath *et al.*, (2003). In addition to push-pull and stay factors, it shows what they described as natural (non-migratory) attrition of health workers from various factors including HIV/AIDS and the inflow of newly qualified health professionals in Southern Africa.

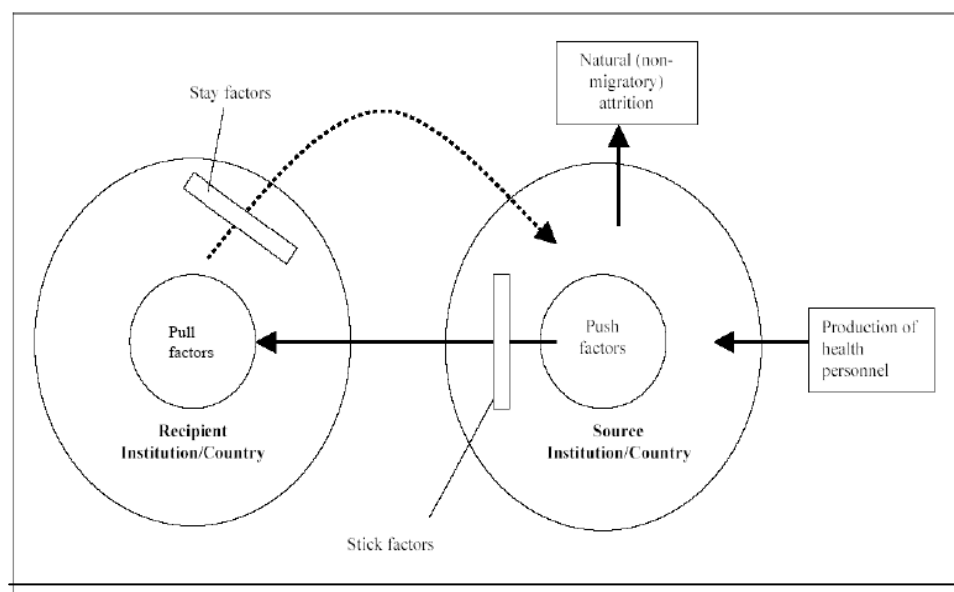


Figure 4.1. Factors affecting the movement of health professionals from countries of Southern Africa

Adapted from Dovlo *et al.* (2004:13) originally from Padarath *et al.* (2003:13)

In a review of literature on African health professional migration, Dovlo *et al.* (2004) found that some African health professionals remain in their countries of origin because of negative feedback from their colleagues who had migrated abroad. Examples of negative feedback included reports of poor working environments and remuneration.

This review has focused on the existing literature which identifies how push-pull and stay factors motivate the migration and stay of African-trained physicians' in their destination countries. Although there is an extensive literature on why physicians' migrate (Mejia, 1979; Martineau *et al.*, 2002; Bach, 2003; Dovlo *et al.*, 2004; Eastwood *et al.*, 2005; Labonte *et al.*, 2006; Padarath *et al.* 2003; Iredale, 2001; Iqbal, 1999; Taylor, 1999; Hogopian *et al.*, 2005; Kingma, 2006; Muula, 2005; Bailey, 2003), little is known about whether the same push-pull factors are at play in the migration of African-trained physicians' to Saskatchewan and how these migrants integrate into the health care system. The present study seeks to determine whether the same endogenous and exogenous push-pull factors identified in the literature influence African-trained physicians' to migrate to Saskatchewan. The study also discusses issues of integration into a new health care system, a theme that has been neglected in most of the existing literature on the migration of IMGs. To determine these exogenous and endogenous factors, selected African physicians' employed in Saskatchewan were asked in a questionnaire to choose from a list of endogenous pull and push factors based on the work of Padarath *et al.* (2003) (see Table 4.1), in order to obtain the specific professional and socio-environmental considerations that had influenced their migration to Saskatchewan. Physicians' who consented to do follow up interviews were then asked to elaborate on the circumstances that influenced their migration decisions.

4.3 Results and discussion

Quantitative data for this section come from the questionnaire survey, while qualitative survey data were taken from the interviews to provide rich insights into physicians' experiences. Physicians explain in their own words their personal motivations for migrating and their experiences as Africans and as physicians living and practicing in Saskatchewan. Their words are often evocative, and frequently point to the importance of factors such as whether spouses and

children are happy here. Consequently, the section addresses not only profession-related but also personal and socio-environmental push-pull factors in African and Saskatchewan. Qualitative and quantitative data are interspersed with discussions linking the data to relevant literature.

4.3.1. Push factors: profession-related factors in Africa

Table 4.1 shows that endogenous push (professional) factors in Africa have influenced physicians' decisions to migrate. Consistent with the literature, the responses in this study's questionnaires suggest that physicians' were influenced by profession-related issues in their countries of origin. Of the 40 multiple responses for what were the primary or secondary factors influencing their migration, 27 respondents (68%) indicated that some aspects of professional practice in their home countries played a role in their decision to migrate (Table 4.2 below). Prominent among them were *working conditions* which were noted by 9 of the 40 respondents (22%).

Table 4.2. Profession-related push factors in Africa

Push factors	South Africa N (%)	North Africa N (%)	Other Africa N (%)	All N (%)
None-No push factors	6 (50)	-	6 (33)	12 (30)
Lack of job satisfaction	2 (17)	1 (10)	-	3 (8)
Work associated risk	1 (8)	3 (30)	4 (22)	8 (20)
Lack of professional development opportunities	1 (8)	3 (30)	4 (22)	8 (20)
Working conditions	2 (17)	3 (30)	4 (22)	9 (22)
All	12 (100)	10 (100)	18 (100)	40 (100)

N= Number of responses

%= Percentage of responses

Source: Questionnaire data (2007-08)

* Note: Respondents were asked to identify primary and secondary reasons for migrating to Saskatchewan. Consequently, data presented in this section are for both primary and secondary reasons for migrating.

A female South African trained physician currently practicing in a Saskatchewan city speaks of the economic situation that influenced her decision to migrate. Although economic factors were not listed as a push factor and by the classification for the study, may be considered a non professional-related push factor, it is certainly a major professional push factor for most African-trained immigrant health professionals.

...I was practicing [in] a big hospital. I was well integrated into [the city] so I didn't really leave for social reasons as conditions for me were quite good, except economically we were really struggling. I had been a student and you know doctors in [South Africa] we're not paid very well, we had student loans to repay ... that kind of precipitated coming.

Researchers who cite income differences as a motivating factor for the migration of health care workers from the developing to the developed world have been criticised for their inability to

explain why, for instance, nurses from the United States who have one of the highest salary scales still migrate to other places (Kingma, 2006), but for the above physician at least, it is obvious that the difference in salary scales between South Africa and Saskatchewan was a consideration for migrating. In large part this follows from inadequate funding of health care systems in African nations, which is a major reason for the inability of African countries to pay their health care workers adequate wages. This continues to trigger migration to developed countries where incomes are comparatively high. Studies of the migration of African-trained physicians' and nurses have repeatedly cited poor remuneration as a major push factor (Eastwood *et al.*, 2005; Bach, 2003; Padarath *et al.*, 2003; Labonte *et al.*, 2006; Muula, 2005). Similarly, higher wages paid in US dollars is cited as attracting Canadian physicians' and nurses to the United States (Eastwood *et al.*, 2005; Iqbal, 1999).

Work associated risk and lack of professional development opportunities were each identified by 8 of the 40 multiple responses (20%) as important. Only 3 of the 40 (8%) cited lack of *job satisfaction* in their home country; two-thirds of these were from South Africa (2 of 12 or 17%).

A West African physician discussed his decision to pursue post graduate medical education in the United Kingdom because of limited post graduate opportunities at home.

By the time I left, there was.....limited post graduate opportunities in [home country]...and you would have to continue working as a non specialist [even] if you wanted to become a specialist.... whereas in [the] UK and Canada, you start your post graduate training immediately after medical school. [home country] is different, you have to workmost people who stay will not undergo any post graduate training.

In part this may be due to limited educational facilities in African nations. For instance, according to the Foundation for Advancement of International Medical Education and Research (2006),

although Ghana had a population of 19,894,014, more than half of Canada's 31,592,805 people, it had only three medical schools as of 2001, compared to 17 medical schools in Canada.

The following quote is from a South African trained physician who was more concerned about the health risk associated with practicing in a country battling infectious diseases. Although he said it was not the main influencing factor for his own migration, he admitted it was a major issue for most health care professionals in his home nation.

....well, obviously the risk is, there is a risk everywhere but in Africa and especially [South Africa], there is a lot of HIV, a lot of hepatitis you know those types of illnesses. Also the amount of trauma that you see is way higher than here. You see a lot more bleeding patients basically.....

A study focusing on the impact of HIV/AIDS on the health sector based on national survey of health personnel, ambulatory and hospitalised patients and health facilities by Shisana *et al.* in 2002 for the South African Department of Health estimated a 15.7% prevalence of HIV/AIDS among health professionals in both the public and private health facilities in four states of South Africa. HIV/AIDS prevalence was estimated to be 20% for younger health professionals aged 18-35 years. They also found that HIV/AIDS impacted the health care system through loss of staff due to illness, absenteeism, low staff morale and increased patient load. Black Africans were more at risk of contracting the virus than their white counterparts'.

Not all of the physicians' were motivated by poor working conditions in their country of origin. Of the 40, 12 (30%) attached no significance to the impact of push factors in their home countries to their decision to migrate. This varied by region with fully half of the South African physicians' and greater than half of those from "Other" Africa identifying professional push factors as being insignificant. None of those from North Africa considered those factors to be important. This

trend could be explained by reasons that those from South Africa were influenced by factors other than professional issues. For respondents from the “Other” Africa, most of whom were recruited from the United Kingdom, profession-related push factors in that country were not a major consideration.

4.3.2. Push factors: personal and socio-environmental factors in Africa

As noted from the literature, push factors, regardless of country of medical training, are complimentary. For example, professional push factors operating in Africa are complimented by the personal and socio-environmental push factors in Africa. Table 4.3 below shows the personal and socio-environmental factors that influenced African-trained physicians’ to migrate and practice in Saskatchewan. Collectively, physicians’ were most concerned about the *quality of life and crime rate* back in their home countries. Again there were variations between categories. *Quality of life and crime* was an issue for 9 of 14 (64%) physicians from South Africa. Conversely, none of the North African trained physicians’ identified this issue as a motivator.

Table 4.3 Personal and Socio-environmental push factors by region of origin

Push Factors	South Africa N (%)	North Africa N (%)	Other Africa N (%)	All N (%)
None-no social/personal push factors	2 (14)	2 (50)	2 (13)	6 (18)
Quality of life and crime	9 (64)	-	5 (31)	14 (41)
War, civil conflict and political	1 (7)	1 (25)	3 (19)	5 (15)
Lack of educational opportunities for self, children and spouse/partner	2 (14)	1 (25)	6 (37)	9 (26)
All	14 (100)	4 (100)	16 (100)	34 (100)

Source: Questionnaire Data, 2007-8

* Note: Respondents were asked to identify primary and secondary reasons for migrating to Saskatchewan. Consequently, data presented in this section are for both primary and secondary reasons for migrating.

A white South African practicing in a medium-sized city spoke of the violence that characterised the end of Apartheid, although he had left the country before the abolition of Apartheid.

...because of the era that I grew up, the safe environment as a white in South Africa. I remember children riding bicycles and playing in the park and all that stuff and having gone back to South Africa after the abolition of Apartheid, there was a lot of strife and violence and crime and everybody is so scared right now of being hijacked or carjacked or robbed or what ever. You just see all the violence every where and everybody is in locked cars and locked houses and gatesstaying here in [a medium town in Saskatchewan], it's nice because you see kids riding their bikes on the streets and the safety factor is [the reason why] I don't want to return to South Africa. When I see my family living in gated communities and having alarms that makes me not want to go back.

The role Apartheid played in the migration decisions of black and white South Africans in the late 80s and early 90s is worth mentioning. The end of Apartheid saw the change of government to a black majority government. Dissatisfied with the political system and perceived threat of affirmative action that characterised this era, many white South Africans sought security and

better opportunities abroad. Mattes *et al.* (2000) found a high level of dissatisfaction for both black and white South Africans about the cost of living, levels of taxation, safety and security and the standard of public services. However divergences occurred in what was of greatest concern for each race. While white South Africans were concerned with oppression, persecution and personal safety, black South Africans tended to be concerned with relatively low incomes. This could explain the presence of a large number of white South African physicians' in Saskatchewan.⁶

Quality of life and crime was followed by the *lack of educational opportunities for self and children* (9 of 34 or 26% - see Table 4.3 above). From the responses in the questionnaire, the least important socio-environmental and personal factors influencing migration to the province was *war, civil conflict and political repression* (5 of 34 respondents or 15%). Only 6 of the 34 physicians' surveyed (18%) indicated none of the socio-environmental and personal factors had influenced their decisions to migrate.

4.3.3. Pull factors: profession-related factors in Saskatchewan

African-trained physicians' are not only 'pushed' out of their home countries due to the unfavourable conditions in the health care system but are also attracted to the relatively favourable conditions in the health care system in Saskatchewan. Table 4.4 shows profession-related factors attracting physicians' to the Province.

⁶ Concerns about increasing crime rates have been growing in South Africa, especially since the end of the Apartheid era. The study's sample of physicians from South Africa is too small to assess temporal patterns of migration in relation to specific issues of concern in their country of origin

Table 4.4. Profession-related pull factors in Saskatchewan by region of origin

Pull factors	South Africa N (%)	North Africa N (%)	Other Africa N (%)	All N (%)
None-No pull factors	2 (12)	2 (33)	3 (16)	7 (17)
Higher remuneration	5 (31)	1 (17)	4 (21)	10 (24)
More satisfying work conditions	3 (19)	3 (50)	4 (21)	10 (24)
A safe working environment	3 (19)	-	4 (21)	7 (17)
Career development opportunities	3 (19)	-	4 (21)	7 (17)
All	16 (100)	6 (100)	19 (100)	41 (100)

Source: Questionnaire data, 2007-2008

* Note: Respondents were asked to identify primary and secondary reasons for migrating to Saskatchewan. Consequently, data presented in this section are for both primary and secondary reasons for migrating.

Table 4.4 shows that the comparatively *higher remuneration* offered in Saskatchewan was an important factor in decision making for 10 of the 41 (24%) African-trained physicians' who were surveyed. Once again, there were variations between regions, as salary proved an important factor for 5 of the 16 (31%) South Africans but only 1 of 6 (17%) of the North African physicians'. Ten of the physicians' in the sample (24%) were attracted to the more satisfying work conditions in the province compared to 9 of 40 (22%) who were influenced by unfavorable working conditions in Africa (see Table 4.2). More satisfying work conditions had attracted 3 (50%) of North Africans, 4 (21%) of "Other" Africans and 3 (19%) from South Africa. A *safe working environment* and *career development opportunities* were each important to 4 (21%) of physicians' from "Other" Africa and 3 (9%) from South Africa respectively, but this was less of

an attraction to the North Africans. Seven of the respondents identified no significant profession-related pull factors in their decision to migrate to Saskatchewan.

The following quote identifies career development opportunities in terms of job availability, a friendly licensing procedure and introduces a non profession-related but important social pull factor in the existence of a social network that had attracted a West African trained physician to Saskatchewan.

I think there are three main attractions. One, when I was looking at coming to Canada, one of my senior colleagues and a family friend, somebody I really looked up to was already in practice in Saskatchewan. I had visited him and he encouraged me to come to Saskatchewan. His reasons were one, he was already on the ground and he'll introduce me to the system. Two, his opinion was that the registration procedure in Saskatchewan was a little bit more welcoming and three, there was a job. As far as he was concerned, there was an already made job for me.

The above example points to the important role social networks play in the immigration of African-trained physicians' to the province. It is particularly notable and suggestive that there is a chain migration (series of migrations within a defined group) (National Geographic Society, 2005) of people from certain countries to the province. McIntosh *et al.* (2007:2) observed from anecdotal evidence that recruitment of physicians' to some provinces in Canada was through "word of mouth". As the above physician puts it, his friend was already on the ground and was going to introduce him to the system.

Another respondent described his migration to Saskatchewan as a complete accident because it had not been planned. He was on a working holiday, came to Saskatchewan and found the people

so nice; the work opportunities and the pay were good as well. This point to the fact that while some movements may be carefully planned, others may be unplanned and spontaneous.

I didn't leave in a bad time, I left in a good time andat the time I was leaving, the economy was still fairly strong and jobs were available. I didn't leave for any other reasons. I was justtraveling [around] the world [to] do a bit of a working holiday. When I got here I found [that the] people [were] so nice, the [availability of a] work opportunity and the pay was good.....it was a complete accident. (South African in a medium-sized city in Saskatchewan)

4.3.4 Pull factors: personal and socio-environmental factors in Saskatchewan

Life style needs and family pressure may lead to skilled workers seeking to move to places where some of these needs and obligations can be fulfilled. The data collected for this thesis suggest that African-trained physicians' coming to Saskatchewan are also attracted to favorable socio-environmental and personal factors in the province. Table 4.5 shows the number of responses for personal and socio-environmental reasons attracting African-trained physicians' to the province.

From Table 4.5 below, the comparatively *high quality of life* in Saskatchewan appealed to 5 of 10 (42%) physicians from "Other" Africa and South African trained physicians' but was not an important factor for those from North Africa. Compared to socio-environmental and personal push factors, 9 of 14 (64%) South Africans and 5 of 16 (31%) "Other" Africans (see Table 4.3) were influenced by the quality of life and high crime rate in their home nations. The relatively low quality of life and high crime rate in the physicians' home countries was not a push factor for the North African trained physicians' who participated in the study. Again, *educational opportunities for children* in Saskatchewan was a consideration for 5 (42%) of the physicians' from "Other" African nations, 3 (25%) of South and 2 (67%) of North Africans.

Table 4.5. Personal and Socio-environmental pull factors in Saskatchewan by region of origin

Pull factors	South Africa N (%)	North Africa N (%)	Other Africa N (%)	All N (%)
None-no pull factors	3 (25)	1 (33)	2 (17)	6 (22)
High quality of life	5 (42)	-	5 (42)	10 (37)
Freedom of speech and political prosecution	1 (8)	-	-	1 (4)
Educational opportunities for children	3 (25)	2 (67)	5 (42)	10 (37)
All	12 (100)	3 (100)	12 (100)	27 (100)

Source: Questionnaire data, 2007-8

* Note: Respondents were asked to identify primary and secondary reasons for migrating to Saskatchewan. Consequently, data presented in this section are for both primary and secondary reasons for migrating.

The following quote illustrates the experience of a physician trained from South-central Africa who then moved to practice in South Africa. Although he had South African citizenship, he felt his children did not have enough educational opportunities there. By migrating to Saskatchewan he was certain there would be educational opportunities for them.

In South Africa [there is] not [a] lack of opportunities as such, the opportunity came in such a way that [the] lack of the means to give [my kids the] kind of education that [I wanted]. You dreamed if I can put it that way, a kind of education that you want to give to your kids. In [South Africa] they [wouldn't] consider somebody like me, though I had a South African citizenship, they always considered you like you were not [South African] and the education of your kids like...university was very.... Here there is an opportunity for my kids.

Less important was the *freedom of speech and political persecution*. About one-fifth of respondents said they were not influenced by any socio-environmental factors in their migration decisions to Saskatchewan.

For the following South African-trained physician, the decision to migrate was not due to any negative factors at the time of his departure, but he described it as an adventure of the world in which he accidentally found himself in Saskatchewan. He adds that the generally low crime rates and good remuneration partly influenced his decision to settle in a medium-sized city in Saskatchewan.

I actually didn't leave due to any of the negative factors. I actually left because I just wanted to have some adventure and [travel around the world] but obviously it [was the] circumstances here, the low crime rate, amount of money that [you could] make, all those also had a contribution but it wasn't the number one reason for me to work here.

4.4. “Stay” factors

Most research on physician migration does not look at why physicians' decide to stay on, even if they had only intended to stay temporarily. There are arguments as to whether the term migration is the appropriate word to use in the case of skilled worker migration. Koser *et al.* (1997) argued that the word migration is not an appropriate term in the corporate world where skilled professionals engage in short term movements. In the case of physicians' migrating from African countries to Saskatchewan, it appears that the term migration might be very appropriate because a proportion of these professionals embark on what might be a short-term migration but end up staying permanently. That is not to say all physicians' migrate permanently. In the case of nurses, Kingma (2006) observed that many nurses, such as holiday workers, study tour nurses, student migrants and contract workers, embark on temporary migrations. The present study found one African-trained physician who not only migrated to Saskatchewan temporarily but was working to obtain his Canadian medical license so that there would be a door opened for him to return in the future. This is how he explained his reason for immigrating to a medium-sized city on a temporary working visa:

...everything is right, I like working here and living here is also good. The only thing is that, I would rather be home...one of the other things that I actually wanted to do and one of the reasons I came to Canada, is to get my Canadian medical licensure and that's all the exams that am writing now so once that's done, I'll probably go back home. (South African trained physicians).

Respondents were asked to identify “stick” and “stay” factors in their decision to migrate and stay in Saskatchewan, as per Padarath *et al's*. (2003) model. To determine what factors are influencing physicians to stay in Saskatchewan, physicians were asked to choose from a list those that have influenced their decision to stay in Saskatchewan. Table 4.6 is a tabulation of those stay factors.

From Table 4.6 below, the decision to stay in Saskatchewan is influenced mostly *by risk of disrupting family life and education of children*. This was more of a stay factor for 5 of 7 (71%) physicians' from “Other” African nations, 4 (57%) from North Africa and only 3 (13%) from South Africa. In the sample of respondents for the study, it was noted that the South African group as well as the “Other” African group were relatively younger (average ages 30-44), whereas those from “Other” Africa tend to have younger families. In some cases, physicians from the South African group were without an immediate family, hence, the disruption to family life and the education of children was not a consideration. *Local/new lifestyle patterns* were another important consideration for staying in Saskatchewan; about one-quarter of respondents cited lifestyle considerations. The *lack of information on job opportunities back home* and the perceived *deterioration of the health system back home* were less of a consideration for staying in Saskatchewan as a total of only 1 (3%) and 5 (14%) respectively identified these issues as being important. All of those identifying these were South African trained physicians' suggesting that they may have somewhat different motivations for remaining in Saskatchewan.

Table 4.6. Factors that would influence African-trained physicians' to stay in Saskatchewan

Stay factors	South Africa N (%)	North Africa N (%)	Other Africa N (%)	All N (%)
New social and cultural bonds	8 (35)	1 (14)	-	9 (24)
Local/new lifestyle patterns	6 (26)	2 (29)	2 (29)	10 (27)
Risk of disruption to family life and education of children	3 (13)	4 (57)	5 (71)	12 (32)
Lack of information on job opportunities back home	1 (4)	-	-	1 (3)
Deterioration of health system back home	5 (22)	-	-	5 (14)
All	23 (100)	7 (100)	7 (100)	37 (100)

Source: Questionnaire data, 2007-8

* Note: Respondents were asked to identify primary and secondary reasons for migrating to Saskatchewan. Conquently, data presented in this section are for both primary and secondary reasons for migrating.

The decision to stay in Saskatchewan may also be influenced by well-established business ventures of spouses or partners. For example, a female physician pointed out that her husband's business in Saskatchewan served as a stick factor influencing her to stay.

Physicians' are one group of health professionals whose services are in demand, hence they have the choice to move almost anywhere they want. Again, it takes time to commit to staying and practicing in a particular place. For a West African trained physician who had travelled to parts of Europe and North America for the last eight years, his family had established good friendships with people in both continents and their continued stay in Saskatchewan was dependent on how

things go for them in the future. This is also reflective of new social and cultural bonds, which were cited in 9 of the 37 (24%) responses. In his own words he says:

I've sort of moved round a bit and established friendships so we'll see how it goesbut we want to be here for a bit and see how things go.

A South African trained physician echoed the desire, especially among young physicians', for improved work conditions in their home countries. She has not decided if she will settle in Saskatchewan; her continued stay will be dependent on deteriorating conditions of work back home. However, she appreciated the efforts being made to improve conditions for senior doctors which she could enjoy if she goes back home with her experience abroad. As to whether any major changes in the health care system in her home country will attract her, it will depend on circumstances at the time.

They are making [the effort] for example salaries have gone up by 30% since I left, which is huge and if I go back, I'll have a more senior position [where] I will have junior doctors who can do pretty much a lot of the boring hard work but if it gets really, really bad there then I'll stay [here] (South African in rural Saskatchewan).

Finally, professional, personal and socio-environmental factors may sometimes point in different directions to the priorities of physicians. For a West African-trained physician, the decision to migrate from a big city in the United Kingdom to a medium-sized city in Saskatchewan was not a matter of safety at work but safety for his children. Practicing in a medium-sized city in Saskatchewan had also given him a balance between work and family and for this reason he does not intend to consider practice in a larger city.

When I think of safety, I think of safety in terms of environment for my kids....in terms of working environment.....you know it's all about the same really.....to be honest with you in terms of work, I don't know, for me am doing less in terms of the scope of practice. Practice is very limiting here. If I end up in a University hospital, then maybe it will be better but am not sure that after tasting life here, in a small city I'll want to live in a big city where there is traffic jams so for me it's a balance.

4.5. Conclusion

This chapter has examined the motivating factors for African-trained physicians' leaving their home countries to practice in Saskatchewan, as well as factors affecting their decision to stay in Saskatchewan. Consistent with previous studies, the study found that push and pull factors worked together to influence the migration decisions of African-trained physicians'. Physicians' were influenced by both endogenous and exogenous push and pull factors in their countries of origin and in Saskatchewan. Notable about the study was the number of participants who indicated that no push and pull factors influenced their migration decisions. Physicians' with young families frequently indicated they will stay in Saskatchewan to prevent the disruption of friendships and their children's education.

CHAPTER FIVE

ISSUES OF INTEGRATION

5.1. Introduction

The discussion in this chapter is structured around location of practice, defined as whether respondents are practicing in large (population over 50,000) medium-sized (8,000-50,000) or small (under 8,000) areas. Location is particularly important because, depending on whether physicians' find themselves in an urban, medium or rural area and contingent on their different lifestyle needs, they may be satisfied or dissatisfied with their professional and social integration. The study seeks to find out how African trained physicians' integrated into their new working environments upon arrival, and on the perceived importance of selected professional and social factors to themselves and their families. One of my findings was that African-trained physicians' just like other International Medical Graduates (IMGs), find the licensing procedure in the province not only costly and painful but not a very useful exercise.

5.3. A review of professional and social issues of integration in host nations.

Once physicians' have immigrated to their desired destinations, there are some initial barriers and challenges with integrating into the health care systems, and into the societies in which they find themselves. One of the most important is accreditation. Boyd *et al.* (2007) found immigrant professionals to Canada were more likely to have difficulties during the accreditation processes because their foreign degrees are often not recognised. They also lack Canadian work experience and in some cases their language proficiency is considered insufficient to practice in Canada. While some immigrant professionals may integrate easily, others are alienated. Integration in the destination country could be perceived at four levels namely, the personal, cultural, societal and

professional levels. Professional integration is particularly important because it reinforces the other issues of integration. This study therefore sought to find out how African-trained physicians' integrated into their new working environment and navigated licensing procedures. The factors they considered important to the professional, social and personal integration of themselves and their families were also considered.

Registration and licensing is a major barrier that IMGs have to overcome in every province in Canada. Although Canada recognises the value of immigrant professionals to the economy of the country, the accreditation process is a major barrier that they must overcome. Re-accreditation is viewed as very important in that it assures public health and safety (Boyd *et al.*, 2007). Physician licensure in Canada falls under the jurisdiction of medical regulatory authorities in each province. The CPSS, which is the licensing body for physicians' in the province, does not recognise the medical credentials of physicians' from countries outside of the United States, the United Kingdom, Ireland, Australia, New Zealand, South Africa and Canada as well as some American and British medical schools in the Caribbean. In order for physicians' outside of the above-mentioned countries to qualify, they have to go through the following stages

- demonstrate competency in English with a suitable Test of English as a Foreign Language (TOEFL) score
- pass an evaluation and qualifying exam
- qualify for a residency position
- possibly go through an assessment program, not currently offered in Saskatchewan. (Saskatoon Open Door Society, 2006)

There are five categories of licenses, namely full, temporary, provisional, special and educational licenses (CPSS, 2008). Audas *et al.* (2005) found variations between provinces in the issuance of full and provisional licenses. IMGs with degrees from medical schools listed in the World Directory of Medical Schools (published by the WHO) or Medical Schools listed in the

International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER) are recognised and assessed, based on 24 months of approved postgraduate training, full licensure in the country where medical training was taken, or a pass standing on the Medical Council of Canada Evaluating Exams (MCCEE). In a situation where physicians' do not meet the afore-mentioned qualifications, they are required to complete the Clinician's Assessment and Professional Enhancement (CAPE) program. A result in CAPE must be accepted by the CPSS before IMGs are given provisional licenses to practice in Saskatchewan (CPSS, 2008). There is, however, a barrier for acquiring full licensure due to the country wide requirement that physicians complete post-graduate training, especially because of the small number of residency positions for IMGs (Audas *et al.*, 2005, Boyd *et al.*, 2007)

According to Bach (2003:16), "licensing procedures are viewed as lengthy, complex and a costly process that may delay or prevent integration into the destination workforce". He added that health professionals fleeing political turmoil may find it more difficult to provide the necessary documentation for licensing, thereby hampering their chances of obtaining licences to practice their profession. Regarding the cost international health workers have to incur in completing the licensing procedure, Coolican (2007) writes that a program designed by the Saskatchewan Institute of Applied Science and Technology (S.I.A.S.T) to help internationally educated nurses (I.E.Ns) get licensed was unattractive to prospective students because it cost them \$6,100 for tuition fees alone. The absorption of half the cost by the provincial government was implemented to enable more students to enrol in the program.

In a similar way, even though the provincial government of Saskatchewan announced a \$115,000 program that would help to cover the tuition fees of IMGs to prepare them for their medical licensing exams, IMGs still have to bear part of the cost. This could cost a “newcomer” about \$5,000 (French, 2006). Moreover, as the president of the Association of International Medical Graduates of Saskatchewan indicated in the Saskatoon *StarPhoenix* on November 28, 2006, passing a licensing exam is “just a first step”, but that the “the real bottleneck is how to get a position in residency”.

Bourgeault (2007) and Dauphinee (2003) both identified barriers to the integration of IMGs. These factors include poor information available for prospective immigrants overseas, difficulty in having their educational credentials recognized, difficulty navigating through policies, practices and procedures for registration, and the time and cost associated with having their credentials assessed in Canada. On the issue of poor information available to prospective immigrant health care workers, Bourgeault (2007) found that even in instances where IMGs are lured or nominated through selective recruitment by immigration policies which often seek the brightest of IMGs, the reality only hits them when they get to Canada and they realize that they have to go through an extensive licensing procedure including passing several standardized exams to get into practice.

As indicated in the preceding paragraphs, the licensing procedure is one that comes in stages and for each stage, IMGs would have to adjust psychologically and financially to meet the challenges of getting licensed. Wong *et al.* (2008:55-57), studying the experiences of getting recertified in Ontario as an IMG, identified four themes in this recertification process. The first theme was what they termed the training entry barrier; their study’s respondents described the admission

process as “logistically difficult, impersonal and stressful”. The other three themes they described as the “three phase process of loss, disorientation and adaptation”, which were described as the phases when IMGs experience personal and professional loss, professional and personal disorientation in the early months of training, and finally adaptation through various coping strategies in the recertification process.

IMGs not only seek their professional integration, but also the professional and personal integration of their families. Han *et al.* (2006: 193-199) identified a four-fold typology of IMGs based on their degree of integration into rural Victoria in Australia. The first group they identified were the “integrated”, which included those who made friends and integrated significantly into rural communities. They also found out that their practice offered considerable professional satisfaction and they enjoyed patients’ appreciation and loyalty. These rural communities also offered a safe place to raise children. The next group was the “ambivalent”; unlike their integrated counterparts, this group of IMGs was more concerned about family, education, employment, rural life, and practice issues. The third group was the “fence sitters”, those who desired to practice close to a cosmopolitan centre where they could enjoy both urban and rural practice and life styles. The fourth was the “satellite” operators, characterised by the desire to fulfil the mandatory training then move into the city when they were qualified to move there.

Kingma (2006:70) noted that leaving children behind can be traumatic for migrant nurses, and in situations where children accompany the migrant nurse, there are some initial challenges. For example there is a difficulty in finding child care in the absence of family members and it is even difficult to build social networks at the work place in situations where the migrant nurse is not

welcomed by colleague workers into the work environment. Marger (2006) found that educational opportunities and family's physical security are top priority for Canadian business migrants.

A review of the literature on health-professional migration shows a gradually increasing focus on issues of integration in the destination countries. Han *et al's.* (2006) typology of the degrees of integration of IMGs into rural societies of Australia is especially important in understanding the integration and retention of IMGs in rural areas. Although the study was done in rural Australia, it could be useful in evaluating the retention of physicians' in rural areas anywhere in the world. As a general rule, comparative study of urban, rural, interprovincial or regional migration of IMGs should look at not only migration itself but also at the degrees of integration. In general, it could help to understand issues around the integration and retention of IMGs and physicians' in different locations.

While Han *et al.* (2006) focused on IMGs in rural Australia, this present study will focus on three geographical categories based on characteristics peculiar to each area (ie size of community) and how to better retain African-trained physicians' in Saskatchewan. Although Saskatchewan has the highest proportion of African-trained physicians' in Canada, little research has been done about how they have integrated into the health care system. This study seeks to fill that gap.

5.4 Results and discussion

This section is based on questionnaire survey results and interviews interspersed with discussions. Sub-divisions relate to professional integration, personal/social integration of

physicians' and their families. The list of determinant for professional and personal/social integration is drawn in part from the literature (e.g. from Iqbal, 1999, and Taylor, 1999), and is also informed in part by my own experience as a newcomer to Saskatchewan (thinking about the issues that had been important to me and other students adjusting to a new country and society)

5.4.1. Professional integration

Consistent with the literature about IMGs' experiences with recertification, respondents for the study had navigated the licensing procedure and acquired a temporary, provisional or full license. There are two legitimate routes to getting licensed in a Canadian province. The first is the residency program, which provides three options. The first option is the Canadian Resident Matching process where IMGs have an 8% to 12% chance of getting into residence in a given year. The second is sponsorship by a community, in which a rural or northern community could sponsor the graduate's two year residency program as a general practitioner. The third and final option is the Special Residency Program for IMGs offered by the College of Health and the College of Medicine; this program reserves five residencies per year for IMGs. The second route is the assessment process reserved especially for IMGs with recent experience (Saskatoon Open Door Society, 2006).

While the medical credentials of African-trained physicians' from South Africa and the United Kingdom were evaluated based on the assessment program, there were a few who had difficulty getting their medical credentials recognised either because they had been out of practice for some time or they came on student visas and after their programs had difficulty securing positions in

Saskatchewan. A physician from south-central Africa, practicing in an urban area, spoke of his experiences of getting licensed in Saskatchewan.

I came here in 2001 and then I stayed out of practice for five years and by that time I was then writing my Medical Council of Canada Exams to get a job after staying so long. to practice was not easy. People from South Africa come here and they don't have problems getting a job. I still had a problem because I stayed out of practice for five years so the guy that sponsored me, sponsored me as a surgical assistant so I was then working in the hospital as an assistant.

Although this respondent had some experience practicing medicine in South Africa, it was difficult for him to get into practice when he moved to Saskatchewan because he had stayed out of practice for five years. To get into practice as a physician he had to first take up a position as a surgical assistant. Kingma (2006:71) described this phenomenon in her study of internationally trained nurses searching for work abroad as de-skilling, which is “the loss of skills due to lack of regular practice and active use”. According to her, this process is not only damaging to the emotions of internationally trained nurses but an insult to their professional capabilities. This is no different for some African-trained physicians’ in Saskatchewan who have to take up certain jobs in the health sector with the hope of getting into practice some day.

It is not the case that IMGs always obtain a job in their field of training; many have to take up other related or unrelated jobs to survive. For example, the 2001 Population Census reports that 90% of Canadian-trained physicians’ were practicing as physicians’, compared to only 55% of IMGs (Statistics Canada, 2001). Also, 33% of IMGs were employed in occupations unrelated to their medical training. Krau (1983) for example, found that Eastern European immigrants who found the same jobs as those in their home countries were more likely to integrate into their destination societies.

The following North African-trained physician, practicing in a medium-sized city, speaks of his dissatisfaction with his current job as a surgical assistant. For him to be satisfied professionally he would need to get back to practice as a general surgeon.

Am not satisfied professionally, I am just doing this job temporarily and to be satisfied to practice again is to work again as a doctor, have my patients, my own office. [It will give me satisfaction].

It was important to obtain views of not only those currently in practice but those still having difficulty navigating the licensing procedure. A respondent had some interesting insights into the frustration of getting licensed in the province as an IMG⁷. Although he admits that he was not supposed to be practicing because he came on a student visa, he was still optimistic that if he passed his exams, his chances of getting into residency would be high. However, for him it was a mirage.

I thought if I can [pass] my exams, I can just get into the system. Another problem was, I was not an immigrant. Let me put it that, I was on a student visa so I wasn't supposed to be in but then I could see that even if I was an immigrant, [it] is not easy because I know of 25 IMGs most of whom are immigrants and have been here for a long time, they have their exams as well but still they are far off from residencies and I fully appreciate that residency is one of the important things..... (Urban IMG)

Boyd *et al.* (2007), using data from the 2001 population census on the reaccreditation and occupations of immigrant doctors and engineers, observed that passing the Medical Council of Canada's Evaluating Examination is not an automatic entry into medical practice in Canada. In some provinces IMGs still spend two years doing post graduate training in a Canadian university to practice family medicine or five years if they want to practice as a specialist.

The literature makes it clear that IMGs everywhere find recertification exercises costly, painful and lengthy. Respondents for this study agreed to this fact. For those who practiced in other

⁷ This respondent was an IMG originally trained in Asia. He was the only unlicensed IMG who volunteered to participate in this study.

developed nation like the United Kingdom, it was a fruitless exercise in that they felt well enough trained to practice in Saskatchewan. Not only did they feel well trained, they were frustrated by the nature of the exams which were meant for new graduates from medical school. The following is an expression of frustration with the licensing procedure from a West African trained physician:

.....I think there is too much paper work involved and form filling and needing to do certain exams which I thought I've been fully trained in the UK. There are so many exams which are barriers. I would rather not subject myself to any exams again because... as many exams as I needed to become a specialist in the UK which is a first world country...there was no need to undergo any kind of assessment again.

For physicians' who had spouses in other health professions, it was frustrating for both them and their spouses. A physician describes the lengthy recertification process of his spouse in Saskatchewan. He is not only frustrated with the system, but also disappointed after he had received assurances that it was going to be easy for his wife to get into the nursing practice.

[My wife] wanted to actually work in the States before coming here, so now she's having to take exams and we have to organize to go to Regina andsessions on lab skills and whatever. Then she would have to do some shift here. None-paid work before she actually writes the Canadian registered nurses exams. It's a very long process which if she were in the States..... All her mates are earning in the States and we have a house in the States right now. We would have organized ourselves but we didn't do that because we thought we were going to have a decent family life here and we had had assurances from the work place that she was going to get a job but as a nurse she needs a license. The licensing body has messed this up in that sense.

Recertification is a major barrier for African-trained physicians' just like any other IMG would have to overcome to practice in the Saskatchewan health care system but what happens after physicians' get into the health care system? What are the important factors to a smooth professional integration?

To uncover some of the factors that helped with the smooth integration of African-trained physicians' into the health care system, physicians' were asked to rank the profession-related factors they considered important in their professional integration. It was found that colleagues who had been in the system for some time could be very helpful in physicians' integration and it was interesting to tease out their appreciation of the help colleagues offered during their initial professional integration. Location of practice was also an important variable in how well physicians' integrate into their communities of practice. For example, those practicing in small communities find very few who could provide help, while in a large city, there could be many potential mentors.

The following table and quotes illustrate which factors physicians' found most important to their professional integration in relation to their location of practice. Table 5.1 shows that 54% of physicians' perceived the medicare system (universal health care system) to be important, whereas only 21% perceived it as unimportant to their professional integration. There was significant difference between physicians' in urban settings, where 66% indicated the medicare system was important, compared with only 33% for rural physicians. Physicians' in urban areas could be looking to advance their careers so for them practicing in an urban area could give them access to all the facilities. In contrast, those in rural areas may not be as concerned about career advancement.

Table 5.1. Perceived importance of the medicare system by location of practice

Medicare system	Urban N (%)	Medium N (%)	Rural N (%)	All N (%)
Important	8 (66)	5 (50)	2 (33)	15 (54)
Somewhat important	2 (17)	3 (30)	2 (33)	7 (25)
Not important	2 (17)	2 (20)	2 (33)	6 (21)
All	12 (100)	10 (100)	6 (100)	28 (100)

Source: Questionnaire data, 2007-8

A South African trained physician speaks of her choice of the Canadian medicare system over the private US system. She felt it was easier to concentrate on her medical practice and alluded to the moral dilemma she would feel if forced to work in the US system.

Yes, I would not be prepared to work in a system that differentiatedI find that really ...frees me up. I feel like I don't have to...I will find it very difficult working in the US. I think choosing my patients will be difficult for me. I worked in the State health in (South Africa) as well. I basically wanted to work in a similar system. (South African in urban Saskatchewan)

Having hospital privileges is an important factor for professional development. Those without such privileges are limited in the scope of their practice. A West African-trained physician practicing in a medium-sized city explains the importance of hospital privileges:

You have to have admitting privileges. It's a privilege you have to work in the hospital, it is not something that you're given, you have to apply for it. You can't just come and say you're a doctor and therefore you should be allowed to work. There is a body that grants you the privilege so having access to those privileges at least enables me to work here.

Table 5.2. Perceived importance of access to hospital privileges by location of practice

Access to hospital privileges	Urban N (%)	Medium N (%)	Rural N (%)	All N (%)
Important	4 (33)	5 (56)	1 (17)	10 (37)
Somewhat important	5 (42)	3 (33)	2 (33)	10 (37)
Unimportant	3 (25)	1 (11)	3 (50)	7 (26)
All	12 (100)	9 (100)	6 (100)	27 (100)

Source: Questionnaire data, 2007-8

Table 5.2 shows that 74% of the surveyed physicians' perceived hospital privileges as important or somewhat important; only 26% did not perceive it as such. The results show an interesting pattern. About 56% of physicians' in medium-sized areas considered it important, compared to only 17% from rural areas. Among those from rural areas, 50% perceived hospital privileges to be unimportant, compared to only 11% for those in medium-sized areas. The observed pattern between locations is particularly interesting as it was expected that physicians' located in urban areas would find hospital privileges more important than those in medium-sized and rural areas.

A physician trained in South-central Africa explains why hospital privileges are important to his practice:

[I] am a kind of guy [who] practice my medicine doing almost everything from the simplest operation to the complicated one, from the less complex case to most complex case so now in certain situations where they want to restrict you.....I find it's very important to me. (physician based in urban Saskatchewan).

Our focus now turns to the question of attitudes towards promotion. The nature of practice in Saskatchewan, as it is throughout Canada, is based on a fee for service. This means that many

African-trained physicians' may have less incentive to strive for promotion or mobility in their specialties. The survey found that opportunities for promotion and mobility varied in importance for respondents (Table 5.3). However, there were some respondents, especially those in teaching hospitals, who found it important but were blocked by factors such as family obligations.

Generally speaking, age does influence the career aspirations of medical professionals. While those in the younger cohorts may be interested in advancing their career, the older cohorts may feel they have reached the peak of their careers. However, the opposite appears to be the case for participants in this study. What stands out for this group is that the relatively older (45+) respondents were more concerned about promotion and opportunities than the younger (<30 and 30-44) counterparts.

Table 5.3 below shows that 41% of physicians' perceived opportunities for mobility unimportant compared with only 26% who perceived it as important. Location had some influence in the perception of promotion or mobility, as 60% of physicians' in rural areas perceived it as unimportant compared to 40% and 33% of physicians in urban and medium-sized cities respectively.

Table 5.3. Perceived importance of opportunities for promotion or professional mobility by location of practice

Opportunities for promotion/ Mobility	Urban N (%)	Medium N (%)	Rural N (%)	All N (%)
Important	4 (33)	2 (20)	1 (20)	7 (26)
Somewhat important	4 (33)	4 (40)	1 (20)	9 (33)
Unimportant	4 (33)	4 (40)	3 (60)	11 (41)
All	12 (100)	10 (100)	5 (100)	27 (100)

Source: Questionnaire data, 2007-8

The following are expressions as to why opportunities for promotion or professional mobility were not an important consideration for a female and a male physician respectively, practicing in urban Saskatchewan.

I think in many ways I have taken less advantage of the promotion than I might have if I had not been sort of tied up with my family. I was Head of Department for several years but I pulled back from that because I just don't [want to] do that sort of administration any more but yes I think I like the sort of equal footing that everybody works on in my department" (Female South African trained physician).

What is important is how much money [you are] going to make as a family physician so the promotion is defined [how many patients]. [If] You are going to an area, how many patients are you going to see...., what they call fee for service. The more patients you see the more money you have so you go where how manyor the area where they hire you, how much they're going to give you, so there is no promotion. (Male physician, 'Other Africa, practicing in an urban area).

The first respondent had been involved with some administrative work in her department, but had taken less advantage of that opportunity because of family obligations. The literature points to the particular difficulties female health professionals face balancing profession and family life (Rosenbaum, 2008, Fox et al, 2006, Glese Verlander, 2004). For the same respondent, promotion

was not important because as she said, everyone was on an equal footing and there was not much of a motivation to strive for a higher position. The last quote is an example of a physician who was more motivated by income considerations than promotion in his profession. For him it is simply a matter of how much money he could make.

Being new to a health care system and society could be very frustrating for some recently recruited physicians'. It takes supportive colleagues and good people to help them make the transitional period as smooth as possible. Of the 33 physicians' who indicated how helpful their colleagues were in their initial integration, 23 (82%) indicated their colleagues had been very helpful or helpful in their integration at the workplace. There were only slight, insignificant differences in location. Eleven (92%) of physicians' in urban areas and 7 (70%) in medium-sized areas perceived colleagues were either very helpful or helpful in their initial integration into the work environment. By comparison 5 (83%) physicians' in rural areas felt the same way.

The reason for the slight differences could be that physicians' in smaller communities have less access to mentors than those in urban areas. As is always the case with every human institution there were those who felt colleagues bullied them rather than supported them at the workplace. This finding is not surprising as it is consistent with what Kingma (2006) found among internationally trained nurses in some developed countries. In her book *Nurses on the Move: Migration and the Global Health Care Economy*, she talks about the feeling of isolation and the bullying migrant nurses experienced at the work place, especially where colleagues pretended to understand them but undermined their skills and refused them help.

The experience of internationally trained nurses is no different from that experienced by some African-trained physicians' in Saskatchewan. Some had expected more support from their colleagues, while others felt they had received tremendous support from their colleagues. One West African physician felt as if he had been "thrown" in the ocean and survived on his own, and another spoke of having felt intimidated in the workplace:

I wish I had better support but I didn't get it so you almost feel like you're being bullied even though you don't want yourself to be bullied. (West African in medium-sized city in Saskatchewan)

It should be mentioned that the physicians from West Africa who experienced difficulties were an exception, as 81% reported positive experiences (quotes below). While the South African population in the province includes some who are not white, the majority of South Africans who participated in this study were white. The "Other" group in my sample were exclusively black. Thus differences between the South African and "Other" categories may well have been influenced by race or stereotyped mind sets. (some "Others" found integration/acceptance fairly easy but no all did so).

The only reason I have stayed in Saskatchewan honestly speaking, after all why do I have to stay here, this is true, none of them [friends] are here today... there are no mountains here, I have the same qualifications... I can get a job... I have a nice department.....who will do anything to support and assist [me]. So I had tremendous amount of support when I got here. That nobody can take away from them. I give them that. (West African in urban Saskatchewan)

I was received with open arms and the process to get to know everyone and getting started was easy. If I didn't know how something in the system worked, I was quickly and with friendliness helped (South African in medium-sized city in Saskatchewan)

5.4.2. Personal/social integration of physicians and their families

Health professionals, as discussed in the conclusion to Chapter 4, are sometimes torn between professional advancement and personal lifestyles. This section focuses on the personal and social integration of physicians' and their families. Ideally, it would have been appropriate to speak with physicians' families about their integration into Saskatchewan but this was not possible due to time constraint and the cost that would have been involved in travelling to physicians' locations of practice to conduct interviews. For the preceding reasons, evidence presented in this section are the views of respondents speaking on behalf of their families.

Duration of stay in Saskatchewan was considered a possible influence on physicians' responses to the social and environmental factors with which they struggled. For example, the perception of an African-trained physician who has lived in Saskatchewan for 10 years might be different than one who had arrived just a month or two ago. Location of practice might not have much influence on factors such as weather conditions and food availability since these are not significantly different in urban, medium and rural places in the province. Nonetheless, a much greater variety of restaurants and grocery stores are to be found in urban centres. Country of origin was expected to be less significant, except for physicians' who had practiced in other provinces in Canada or other countries and had experienced different cultures and environments.

Table 5.4 shows duration of stay and socio-cultural and environmental factors physicians' found important or unimportant to their personal and social integration. Overall, it shows that the duration of stay did not have much impact on the socio-cultural and environmental factors

physicians' considered important as both recently-arrived African IMGs and those who had stayed longest identified similar factors as having affected their social and personal integration. A ranking of the socio-cultural and environmental factors said to be important for the personal integration of African-trained physicians' included a safe environment (63%), weather and religious worship (48% each), recreation (39%), and community services and welcome (27% each). Least important in the ranking was food, which was identified as important by 21% of respondents. Again, ratios of important to unimportant responses for different factors shows safe environment (21/3) was very important, followed by worship (16/9), weather (16/5) and recreation (13/7). Community services (9/12), community welcome (9/10) and food (7/15) were less important to the personal and social integration of African-trained physicians'. Patterns of socio-environmental factors important to physicians social and personal integration did not change much with duration of stay in Saskatchewan. The next step for this research will be to survey those IMGs who had moved on to see if they are similar to those practicing in Saskatchewan

Having lived in Ontario for five years, this physician trained in South-central Africa speaks of the differences in social life and climate for the provinces of Ontario and Saskatchewan:

Ontario is a big [province and] in Ontario nobody cares about nobody. It's the life in every big city in the world. If you are in your corner, nobody cares about youso you go about and nobody really follows you around but Saskatoon is a little bit different. Everybody wants to know what you do and [it's] exceedingly too cold compared to Ontario. You know, what is here is nothing to do with what is in Ontario...is totally another country. It's cold, is cold, I don't deny it. You know, me coming here...., is really like am crossing the border to another country. (A physician trained in South-Central Africa practicing in an urban area of Saskatchewan)

This same physician indicated that worship was very important for his social and personal integration, as he had found a church in which to worship. This is what he says about the importance of a worshipping community in integrating into a new society:

I believe very much in God. If there is one single [place] where you will not be lost is in worship. It is where people want to meet you [and] teach you. [A] Worship[ing] [community] is the easiest place you go to hide yourself. It's just amazing, the way they can integrate you. Part of getting into the society is through a worship[ing] [community]. If you are a true worshiper you won't have any problems.

Table 5.4. Duration of stay as a determinant of the social and physical factors physicians found important to their initial social/personal integration

Factors	All Responses			Duration of stay		
	Important N (%)	Unimportant N (%)	Ratio of important/ unimportant	Important Factors N (%)		
				<3yrs	4-10yrs	>10yrs
Weather	16 (48)	5 (15)	16/5	9 (69)	7 (50)	-
Food	7 (21)	15 (45)	7/15	3 (23)	3 (21)	1 (17)
Community services	9 (27)	12 (36)	9/12	6 (46)	2 (14)	1 (17)
Community welcome	9 (27)	10 (30)	9/10	4 (30)	3 (21)	2 (33)
Recreation	13 (39)	7 (21)	13/7	7 (53)	3 (21)	3 (50)
Safe environment	21 (64)	4 (12)	21/4	7 (53)	10 (71)	4 (67)
Worship	16 (48)	9 (27)	16/9	6 (46)	9 (64)	1 (17)
N (%)	33 (100)	33 (100)	33/33	13 (100)	14 (100)	6 (100)

*Respondents were asked to identify all factors that were important/unimportant to their integration in Saskatchewan. Consequently, total percentages do not add up to 100%

As already mentioned in preceding pages, location could impact how well people including physicians' integrate into a community. Weather of course is much the same throughout

Saskatchewan but some people adjust to it more quickly than others. The following discussion focuses on location of practice as a determinant to what socio-cultural and environmental factors physicians' found important/ unimportant to their initial social and personal integration.

Table 5.5 below shows location of practice did not have much of an influence on the socio-environmental factors physicians' perceived important in their personal and social integration. A ranking of the socio-environmental factors physicians' perceived important shows physicians' placed a higher priority on a safe environment (58%), followed by weather (48%).

Generally, physicians' indicated a safe environment, worship, weather and recreation were important to their social and personal integration. A safe environment was identified as important to 60% of physicians' in urban areas, followed by worship (47%). Least important for urban physicians were recreation and food (20%) each. Weather and recreation were indicated as important to 58% of physicians' in medium-sized cities respectively, followed by a safe environment (42%). Rural physicians' were equally concerned about a safe environment as 83% indicated it was important, followed by worship (67%). Least important to rural physicians' was community services (17%).

From Table 5.6 below, region of origin did not have much of an influence on what factors physicians' perceived important to their social and personal integration. A total number of 12 (100%) respondents from South Africa, 4 (100%) from North Africa and 17 (100%) from "Other" Africa indicated what socio-cultural and environmental factors were important or unimportant to their social and personal integration.

For this West African trained physician recruited from the United Kingdom and now practicing in a medium-sized town in Saskatchewan for less than a year, adapting to food was a very easy thing for himself and his wife.

[I] am very adaptable and my wife is also good in picking up so we're okay with that. In fact we haven't even managed to find where we can buy (food stuff from home country)...we're okay. We will find it with time.

Physicians' may be well integrated professionally but that might not be the case for their social integration. This South African trained physician speaks of the difficulty in integrating socially. Although she found her neighbors very enlightened it took several years to integrate into her neighborhood.

I will say professional integration was very easy. I wouldn't say social. I think my social integration has always been quite difficult. I think I.... it so different either than you probably find the same thing. It's so different but over the years I haveespecially in this sort of neighbourhood which is very mixed. It's got a mixture of professionals, engineers, doctors, lawyers, people in business, school teachers, like it's a real mixed area, everybody working so I find it a fairly enlightened area.....I find my neighbours very enlightened not much prejudice and so I find that I have integrated quite well but it's taken years and years and am sure it's me than more of them. (South African trained physician practicing in urban Saskatchewan).

Table 5.5 Location of practice as a determinant of the social and physical factors physicians found important to their initial social/personal integration

Factors	All Responses			Location of Practice		
	Important N (%)	Unimportant N (%)	Ratio of important/ unimportant	Important Factors N (%)		
Weather	16 (48)	5 (15)	16/5	Urban 6 (40)	Medium 7 (58)	Rural 3 (50)
Food	7 (21)	15 (45)	7/15	3 (20)	2 (17)	2 (33)
Community services	9 (27)	12 (36)	9/12	4 (27)	4 (33)	1 (17)
Community welcome	9 (27)	10 (30)	9/10	4 (27)	3 (25)	2 (33)
Recreation	13 (39)	7 (21)	13/7	3 (20)	7 (58)	3 (50)
Safe environment	21 (64)	4 (12)	21/4	9 (60)	5 (42)	5 (83)
Worship	16 (48)	9 (27)	16/9	7 (47)	4 (33)	4 (67)
N (%)	33 (100)	33 (100)	33/33	15 (100)	12 (100)	6 (100)

* Respondents were asked to identify all factors that were important/unimportant to their integration in Saskatchewan. Consequently, total percentages do not add up to 100%

Generally, African-trained physicians' felt their children and spouses had adopted very well into the communities and neighbourhoods they lived. Everything ranging from educational facilities to recreational facilities were easily accessible to their children. Physicians' perceived their neighbourhoods as very safe for their children. This physician from West Africa now practicing in a medium-sized city in Saskatchewan had this to say about the social integration of his kids:

Here when they go out you have to baby sit them in a way and it's worse in the big cities. It was worse in London, it was worse in St Louis. America is even terrible but in a city like this, which is small enough, you know you can be reasonably comfortable allowing the kids to go out and play as long as it's not near the street andon the road to get knocked down by a car, even that, the traffic is so sparse. It's a very safe place to be".

Table 5.6. Region of origin as a determinant of the social and physical factors physicians found important to their initial social/personal integration.

Factors	All Responses			Region of Origin		
	Important N (%)	Unimportant N (%)	Ratio of important/ unimportant	Important Factors N (%)		
				South Africa	North Africa	Other Africa
Weather	16 (48)	5 (15)	16/5	4 (33)	2 (50)	9 (53)
Food	7 (21)	15 (45)	7/15	3 (25)	1 (25)	3 (18)
Community services	9 (27)	12 (36)	9/12	3 (25)	1 (25)	4 (24)
Community welcome	9 (27)	10 (30)	9/10	5 (42)	1 (25)	3 (18)
Recreation	13 (39)	7 (21)	13/7	7 (58)	-	6 (35)
Safe environment	21 (64)	4 (12)	21/4	7 (58)	2 (50)	12 (71)
Worship	16 (48)	9 (27)	16/9	5 (42)	2 (50)	9 (53)
N (%)	33 (100)	33 (100)	33/33	12 (100)	4 (100)	17 (100)

* Respondents were asked to identify all factors that were important/unimportant to their integration in Saskatchewan. Consequently, total percentages do not add up to 100%

Not all physicians' felt their communities were safe for their children. One physician from South-central Africa perceived his rural community to be unsafe for his children. His specific concerns were with illicit (recreational) drug use and "too much freedom"

Although physicians' felt their spouses had integrated well socially, they were particularly concerned about employment for them. This South African trained physician speaks of the frustrations her spouse had to go through in the 1990s when spouses of immigrants did not have the opportunity to work in Canada. She describes the experience of her husband as difficult because he could not work but with the change in policy which she and her husband spearheaded, he now runs a business in Saskatchewan.

It was very difficult in a way not being allowed to be employed so kind of having to work around that was very difficult. I think it was socially very difficult for my husband but once he started his own business, I think a lot of things changed for him especially when he got a big contract to make furniture for a company in New York so once [he] got into that, I think life was much, much easier for him but it took a long time.....

5.5. Conclusion

This chapter focused on the professional and social integration of African-trained physicians' in Saskatchewan. African-trained physicians' in Saskatchewan, especially those recruited from other developed countries, found the recertification process not only costly and painful but also not useful to their practice. This finding confirms and extends on the literature about the perception of recertification as costly, lengthy and time consuming for international health care workers. Physicians' location of practice did not have much of an influence on their perception of profession-related factors of integration in Saskatchewan. Physicians' in all locations found the medicare system important to their professional integration. Hospital privileges were more important to physicians in medium-sized areas than rural and urban areas. The majority also perceived opportunities for promotion and professional mobility unimportant to their integration.

African-trained physicians' integrated well into the health care system and many have remained at their current location of practice because of the tremendous support they received from colleagues at the work place. Physicians' were generally positive about their colleagues at their initial integration into the work place especially those in urban and medium-sized communities. This study demonstrates integration at the work place is important in retaining health care professionals.

Physicians' were well integrated socially and personally and had a positive perception of the communities and neighborhoods they lived in. Duration of stay did not play much of a role on what socio-environmental factors physicians' perceived as important to their social and personal integration. Location and origin also had little influence on the environmental and social factors physicians' found important in their personal and social integration. Follow-up interviews revealed some physicians' were concerned about employment for their spouses and unsafe environment in some rural communities for their children.

CHAPTER SIX

CONCLUSION, RECOMMENDATIONS, LIMITATIONS AND CONTRIBUTIONS

6.1. Introduction

In this concluding chapter, I present the major findings of the study, recommendations from respondents, limitations and contributions to literature and policy. I also include some of my personal reflection on this study as a learning experience.

6.2. Conclusion

The migration of African-trained physicians' has attracted media attention primarily because of the supply gap/physician shortage in rural communities and in certain areas of specialization. Issues around licensure and the impacts that out-migration has on African source countries from which where physicians' were recruited have also received some attention.. The out-migration of physicians' from Saskatchewan to other provinces and countries is offset by in-migration of physicians from other countries and provinces. IMGs (including African-trained physicians') have been utilized as a solution to the physician shortage in Saskatchewan but little is known about their motivations and issues around their integration, a gap the current study sought to fill.

The study revealed that both push factors in Africa and pull factors in Saskatchewan influenced the decisions of African-trained physicians' to migrate in order to practice in Saskatchewan. There were differences between the three categories (South, North and "Other" Africa) in the precipitating factors for their migration. Although the majority of African-trained physicians' participating in the study indicated profession-related push factors were the primary precipitating factors for their migration, it was not so much of an influence for all of them. Certain respondents

who were influenced by profession-related push factors in Africa cited work associated risk; this was especially so for physicians' from "Other" Africa. For the North, "Other" and South African-trained, lack of professional development opportunities and working conditions at home were among the factors that influenced them to migrate. Quality of life and crime were among the social and personal push factors for South and "Other" African-trained physician respectively.

Push factors in the health care system and societies of countries of origin were complimented by pull factors in Saskatchewan. African-trained physicians', especially the South African trained, were attracted to Canada by the comparatively higher remuneration. More satisfying work conditions were attractive to the North and "Other" African-trained physicians', while a safe working environment and career development opportunities were considerations for both the South and "Other" African physicians'. The social and personal pull factors that were most important for the South and "Other" African physicians' were a high quality of life and educational opportunities for their children.

Physicians', especially the South African trained group, indicated they hoped to stay in Saskatchewan because of the new social and cultural bonds they had established. New lifestyle patterns in Saskatchewan and the deterioration of the health system back home were equally important to them. Some physicians' were more concerned about disrupting their family life and education of their children since most of them had young families.

This study confirms findings from other studies about health professionals' integration into their host nations. African-trained physicians' in Saskatchewan, especially those recruited from other

developed countries, complained about the cost and complications of the recertification process and asserted that it was not useful to their practice. Most respondents indicated that the medicare system was important in their professional integration. There were, however, diverse responses on the importance of hospital privileges and opportunities for mobility. Demographic characteristics such as gender and age were not found to play an important role in the factors that were important to physicians' professional integration.

Most of the respondents integrated well into the health care system and have remained at their current location of practice because of the tremendous support they received from colleagues at the work place. The general response pattern was skewed toward a male perspective because they formed the majority of respondents for the study, especially for the relatively younger cohorts. Although most of the respondents were generally positive, there were a few respondents from within the younger cohorts who felt colleagues were unhelpful in their integration into the work environment.

Physicians were generally well integrated socially and personally, and most had a positive perception of the communities and neighborhoods in which they lived. The duration of stay in Saskatchewan did not play much of a role in the socio-environmental factors physicians' considered important to their social integration. Neither did location of practice have much of an influence on what factors were important to their social and personal integration. Again country of origin had relatively little influence on what socio-environmental factors physicians' considered important in the first two years of practice in Saskatchewan. Most respondents felt their spouses and children had integrated well into Saskatchewan because all the facilities were

available for them. The only concern for some of them was the frustrations spouses had to go through their unsuccessful search for employment.

The study revealed the kind of “multi-stage” migration occurring between and within developed countries. For example, the majority of physicians’ in the study from “Other” African countries had trained and practiced in the United Kingdom before migrating to Canada. It is not clear if these respondents had intended to use the United Kingdom to reach their desired destination in Canada and for that matter Saskatchewan, or if they were just taking advantage of better opportunities here.

6.3. Recommendations offered by respondents

The study found African-trained physicians’ continued to migrate to Saskatchewan because of push factors in Africa as well as pull factors in Saskatchewan. African-trained physicians’ will continue to choose Saskatchewan as a destination as long as there is a demand for their services. The views of African-trained physicians’, however, did not strongly support the argument in the migration literature that professionals used certain countries to reach their desired destinations, what is termed a “multi-stage” movement of physicians’ (Mejia, 2004, p.208).⁸ The United States is often cited as the desired destination for most health professionals. A number of respondents indicated their plans to move to big provinces in Canada but not the United States. Although respondents for this study may not wish to use Saskatchewan to reach the United States, the

⁸ The study had not attempted to trace physicians who had left the province. The decisions and views of physicians’ who had left would be important in understanding the nature and extent of multi-stage migration in which Saskatchewan is only a stepping stone towards a desired destination.

findings still suggest a kind of internal “multi-stage” migration from less endowed to more endowed provinces.

While most respondents for this study indicated they did not have plans to migrate to other countries, some of them do have intentions to move to bigger provinces like Ontario, Alberta and British Columbia. Although not many of them indicated their intention to migrate, it is still important to try to retain these physicians in their current location of practice. Issues of integration, especially issues around licensure and work for spouses, are important factors in retaining physicians’ in the province. Help from colleagues with integrating into the work environment is very important as physicians’ are more likely to leave if they are not given enough support at the work place.

Physicians’ were frank about the fact that not all their needs had been met here. Certain physicians’ mentioned factors such as weather and income; if they wanted a warmer climate or higher remuneration, they were more likely to move to areas where those could be fulfilled. Some of them also had concerns they wanted health authorities to address.

The following are some recommendations from physicians’ to help with licensure and retention of physicians’ in the province. Recommendations ranged from social support, to improvements with the licensing procedure, to a more liberal system for IMGs, and more funding for equipment and retention programs. The following are several recommendations based on the above mentioned areas of concern:

- Respondents were of the view that physicians' recruited into rural communities should have good support and not be left in solo practice because they were more likely to be isolated and thus to leave. Others felt that physicians' recruited to rural areas should have some form of local orientation other than the one organised by the Saskatchewan Medical Association (SMA).
- Although physicians' appreciated the efforts being made to help with licensing of their colleagues not yet admitted to practice, they suggested it should be hastened to fill in the shortages in the system and at the same time help physicians' and their families. Others called for an improvement in the licensing procedure. They were of the view that once IMGs are accepted to write the Canadian exams, there should not be delays in job placement if they pass all their exams.
- Physicians' were of the view that the insistence in Saskatchewan that IMGs take all their exams was counter-productive because once physicians' have taken all their exams, it makes them more marketable across Canada and they are less likely to stay. They suggest a good balance between making sure that IMGs have the right qualifications and have maintained enough knowledge to practice safely. With a new regulation that allows physicians' certified in one province to practice in other provinces, a lot needs to be done to attract and retain physicians in Saskatchewan.
- They also suggested physicians' from other countries not recognised in Canada should be given the same opportunity as their other counterparts to have their medical training assessed, because they could be equally effective as physicians if they were given the chance to have their training assessed.

6.4. Limitations & contributions

There is no denying the fact that a study of this nature will be fraught with limitations and challenges. A case study of African-trained health professionals in Saskatchewan is not enough to generalise about all African-trained health professionals in Canada. Existing research on the migration of African health care professionals has focused on the numbers, trends and factors accounting for the migration of physicians' and nurses to developed countries, with little

attention focused on other health professionals. It is also important for current studies to include other health workers; Martineau *et al.* (2002) point out that other health professionals like pharmacists and physiotherapists also migrate and practice in some developed countries. It is therefore necessary for future studies of health professionals to be all encompassing including the migrant health workers themselves, given the fact that migration flows of health professionals involve different experiences and streams of health care professionals.

For future research in the areas of IMGs, I recommend a comparative study of the experiences of physicians' from Africa and other continents to determine whether there are differences in the attractions to and integration in Saskatchewan. A follow up study on where IMGs move to could throw light on whether physicians' are involved in a kind of multi-stage migration. It will also be important to study the experiences of the unlicensed group trying to acquire licenses. A study of this nature should involve stakeholders such as the College of Physicians' and Surgeons of Saskatchewan and the Saskatchewan Medical Association at the initial stages of the study so they could encourage more of their members to participate in the study.

Due to logistics, time constraints and the busy schedules of respondents, the sample size was purposive and small. Interviews were conducted with a small sample and, analysis was then based on their narratives. Most of the follow-up interviews were also conducted on the phone due to the geographic location, and time constraints of some respondents. This took away some of the non-verbal expressions which a face-face interview gives. The preceding limitations make it difficult to generalise with other IMGs although their experiences might be similar.

My own personal biases, status and origin might have played into and shaped the outcome of this study. I am not a physician, have never been engaged in any research of this nature and also am not a Saskatchewan citizen so my own personal biases of physician migration from Africa to Saskatchewan might have had some influence on this study. For example, my interest in a research on African-trained physicians' stems from recent strikes of health professionals in Ghana where I come from and lived most of my life. Grievances of these striking health professionals had been poor working conditions and low salaries. Some of them who were granted interviews on radio and television spoke blatantly of looking for an opportunity to travel abroad, because there were better conditions of service. This set me thinking as to whether they would stay and work in Ghana if their salaries were increased and working conditions improved. Also the question that I asked myself was if it would be easy for them to integrate and work abroad? Now in Saskatchewan I thought I could explore the motivations and experiences of African-trained physicians' in the province. As an African I have experienced shortages at home, which has not only sparked my interest in the topic but also affected my positionality.

My own positionality in this study came to light during the interview process when some respondents threw back the question about the motivations for migration at me and when I indicated I came for education and after my program would like to explore the job opportunities here, they felt I was going to tow the same line as them. One respondent thought I was even in a better position of getting employment in Canada because I had received some education in Canada.

Notwithstanding the above-mentioned limitations, the study has contributed to the migration literature on the push-pull factors precipitating the migration of African-trained physicians' to Saskatchewan. It has also given insights into how African-trained physicians' have integrated into the health system in Saskatchewan. Recommendations from this study could help with policies and programmes that will help retain and integrate those having difficulty integrating into the health working environment.

6.5. Personal Reflection

My interest in researching African-trained physician migration to Saskatchewan was born during a labour dispute between health care workers and the government of Ghana over better salaries and working conditions. I was particularly struck by statements of health worker which pointed to their intentions to migrate abroad where they could enjoy better conditions of service. Through my email correspondences with my supervisor, Dr. Robert Stock, I found out that there were many African-trained physicians' in Saskatchewan. Having succeeded in securing admission into the University of Saskatchewan in 2006, I thought it was a good opportunity to explore the varied reasons why African IMGs have emigrated to Saskatchewan to practice medicine, if only temporarily in some cases, and to understand their feelings about their integration upon arrival.

In a sense, the perspective that I tried to capture was that of the migrant physicians' themselves (and their families, if indirectly). In some ways this was a natural fit for me. My own experiences as an international student coming to Saskatoon, Saskatchewan, in order to pursue graduate school, and my attendant struggle to adjust to harsh winters, unfamiliar foods and a challenging social environment, helped me relate to the experiences of newly-recruited African-trained

physicians' in the province. Like them, I too came to Saskatchewan looking to improve my life, and in their struggles and aspirations I could sometimes see my own.

Nevertheless, this is certainly not the only way in which this study could have been approached. There are varied perspectives to the physicians' migration in Saskatchewan, each valid in its way, but also each demonstrating different attitudes towards the migration. In some cases these are diametrically opposed to one another. Shifting the major focus of this research to exploring these other perspectives would have led to markedly different research questions, would have required completely different sources of data, and would have provided entirely different answers. In short, another approach would have led to a markedly different thesis.

From the Canadian perspective, multiple positions exist. One perspective, held by many in the province, sees this migration in a positive light, specifically that IMGs can and should be utilized as a solution to fill the shortages inherent in the Canadian medical system. Such a perspective might find this study useful as a tool for attracting additional IMGs, or for convincing those that are here to stay, rather than move on to other jurisdictions.

Another potential Canadian perspective holds a negative view of the migration because of who these migrants are. This group, perhaps far smaller than the previous, resents the use of IMGs because of issues surrounding the new arrivals' race and accents, which differ from their own. A third Canadian perspective, again probably held by a minority, is strongly opposed to this migration from the standpoint of international equity. In their view, whatever the cause of the physician deficit in the province, Saskatchewan should be responsible for solving its own

physician shortage and should not “poach” from other countries, stealing already strained resources from countries that are far poorer than Canada.

Finally, the movement of IMGs from Africa to Saskatchewan could also be studied from an Afro-centric perspective, and once again the goal would not be to enhance the movement but instead to stem this tide. Growing up in a developing health care system in Ghana, I have witnessed long waiting hours due the shortage of physicians’. As well, the Government of Ghana has difficulty in prioritising and allocating financial resources to meet the needs and expectations of physicians who have the option of migrating abroad for better opportunities.

In regards to physician migration from Africa, some who are critical of the process would see in it the need on the part of the African governments to address structural problems, in order to limit the need for the physicians to find better opportunities elsewhere, whether through better remuneration for services and working conditions for health professionals or by addressing other push factors. Here, again, the results of this study may be of value, but as guideposts to improving conditions such that the physicians’ would not want to leave. Similarly, the African governments, those who have, in part, been responsible for putting in place the push factors that contribute to the migration of IMGs to Saskatchewan, would also point to the harmful impact on health services in the donor countries that the loss of these highly qualified personnel have generated, though perhaps with less critical emphasis on their own performance and more on the role of western nations in promoting the unequal economic and social conditions that help drive this movement. My intention in this thesis is to describe the factors affecting African-trained

physician migration, rather than advocate for against or for the current heavy reliance of Saskatchewan on IMGs.

My experience of writing this thesis has been a learning process. The methodology had to be carefully thought through to capture the experiences and perspectives of as many African-trained physicians' as possible and to communicate results in the most effective way because of the small sample size that I had to work with. I had initially hoped that the response rate would have been up to half of the African physician population in Saskatchewan. For example, 483 (CPSS, 2007) African trained physicians' were licensed to practice in Saskatchewan in 2007, a potentially big pool of physicians to draw on. The response rate was just 33 of the 124 physicians' who were contacted. (26.6%). Given the busy schedules of physicians, this response rate was actually quite encouraging.

A Questionnaire survey was the initial data collection process that was intended to give as many physicians' the opportunity to be part of the study. A follow up interview was then scheduled if they wanted to elaborate on their responses on the questionnaire survey. Oral testimonies were informative and added physicians' own voice and passions behind their migration and integration to the study. The following quote illustrates this better.

When I think of safety, I think of safety in terms of environment for my kids....in terms of working environment.....you know it's all about the same really.....to be honest with you in terms of work, I don't know, for me am doing less in terms of the scope of practice. Practice is very limiting here. If I end up in a University hospital, then maybe it will be better but am not sure that after tasting life here, in a small city I'll want to live in a big city where there is traffic jams so for me it's a balance.

The quote above was very useful as safety in the form of a statistic could be interpreted as safety at work and not for his family. Numerical information provided a general picture as to the motivating factors and their perspectives about their integration.

Writing up the thesis was a major step in the research process that had to take into consideration both the questionnaire and in-depth interview data. Tables were used to tabulate responses and quotations to add a voice to the numbers. In reality, the whole story of African-trained physicians' motivations for choosing Saskatchewan and issues around their integration was contained in the qualitative data around comparisons with urban-rural-medium, new comers-old timers and married and unmarried. As a first-time user of qualitative data of this source, I was pleasantly surprised at how valuable it was a source of insights. If I were to do this study again, I would probably put more emphasis on the qualitative part of it.

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APPENDICES

APPENDIX A: CONTACT LETTER



Date:

Research project on migration of African Physicians Abroad: A Case Study of Saskatchewan.
Seraphine Kogo, MA Student. Department of Geography, University of Saskatchewan.

Dear Dr.....,

I am writing to invite you to participate in my research project to study the “Push” and “Pull” factors that affect the migration of African physicians coming to Saskatchewan. My study also looks at how physicians of African origin integrate into their new working environment, the barriers that they face in integrating, and how these experiences could affect future migration of African physicians to Saskatchewan. There are no immediate benefits to anyone who participates in this survey, but the study will contribute to knowledge that might bring about policy interventions to address some of the challenges you are facing or might have faced.

Accompanying this letter is a questionnaire. Questions are both closed and open-ended and deal with three main topics. The first section focuses on personal information, medical background and medical specialization. The second section focuses on motivations for migrating (push-pull factors) and migration within Saskatchewan after arrival. The third section focuses on issues of integration which includes initial personal and social integration and your long term integration and plans. I am asking you to read through the questionnaire, and if you would be willing to participate in my research project, please complete it and mail it to me in the enclosed prepaid envelope.

I would also like to conduct a limited number of follow-up interviews to better understand the circumstances that led to the interviewee’s migration and integration into the health care system in Saskatchewan. Please understand that not all people who consent to have a follow-up interview will be contacted or interviewed. There will be a question at the end of the questionnaire asking if you would be willing to participate in a follow-up interview. If you agree to do so, you will be asked to sign at the end of the questionnaire and provide your contact information. The interviews will probably take 1 to 1.5 hours. With your permission, interviews will be audio taped and transcribed. I will also take notes if you do not want the interview to be taped. I have provided my contact information and that of my supervisors at the end of this letter. You can contact me or my supervisors if you have any questions.

The results from questionnaires and interviews will be incorporated into my thesis, which will be submitted for a Masters of Arts degree in the Department of Geography, University of Saskatchewan. Some of the other ways results may be communicated is through academic conferences, publications and public presentations.

This study should pose little or no physical, psychological or social risk to you. However, you have the opportunity to decline to answer any question if it causes distress or for any reason. You could also withdraw your consent to participate in this interview at any time. Only my supervisors and I will be working with the survey results and will have access to the names of participants and the individual responses of those who have been interviewed. When data transcription has been completed, all names will be removed from the interviews. When survey results are reported, whether in writing or orally, care will be taken to ensure that no individual participant is identified personally through indicators such as name or place of practice. If I quote you, I will not use your name, only a pseudonym or general description such as a “physician in rural Saskatchewan”. Your name will not be used in my thesis work or in any possible publication or presentation. The tapes and transcripts will be stored in a safe filing cabinet in Prof. Robert Stock’s office for five years. After five years, all questionnaires and tapes will be destroyed.

The survey should take about thirty minutes to complete. I would be most grateful if you would take the time to complete this questionnaire and return to me in the prepaid envelope enclosed. You may, if you wish, decline to complete the questionnaire, or respond to interview questions at any point in the process. However, please understand that your completion and submission of this questionnaire will indicate your consent to participate in the study. Since identifying data will only be available for those who consent to be contacted for a follow up interview, it may not be possible to withdraw your responses once they have been submitted. If you decide at any point you do not want to be part of this study, let me know so I can destroy your questionnaire and/or tape.

Please let me know if you would like a summary of my findings after I have completed my research. To receive a summary email me at sek675@mail.usask.ca

If you have any questions about the questionnaire or your participation in this study, please ask me, or contact my supervisors at any point. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Science Research Board on (Date). Any questions regarding your rights as a participant may be addressed to the committee through the Ethics Office (306)966-2084). You could call collect if you are an out of town participant.

Sincerely

Seraphine Kogo
Student Researcher

Contact Information:

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APPENDIX B: INFORMED CONSENT LETTER

Department of Geography
University of Saskatchewan
9 Campus Drive, Saskatoon
Saskatchewan, Canada S7N 5A5

Dear Dr.....

I am Seraphine Kogo, a graduate student enrolled in a masters program in the Department of Geography at the University of Saskatchewan. Before I came to Saskatchewan, I studied for my Bachelor of Arts at the University of Ghana.

I am writing to ask for your participation in my survey which looks at the migration of African trained physicians and their integration into the Saskatchewan health system.

Your participation in this survey is very important because it would help us better understand the circumstances that led to your migration and your experience of integrating into the health care system in Saskatchewan. Please if you have any questions regarding this study, you can contact me on (306)966-5675 or email me on sek675@mail.usask.ca

My efforts to reach you on phone have not been successful. I would be grateful if you could indicate below your willingness or otherwise to participate in my survey and mail back to me in the enclosed prepaid envelope so I can mail a questionnaire to you.

Yes, I wish to participate in your survey. Please indicate the address to which questionnaire should be mailed to:

No, I don't want to participate in your survey.

Thank you for your efforts in participating in this survey

Sincerely

Seraphine Kogo

APPENDIX C: QUESTIONNAIRE

MIGRATION OF AFRICAN-TRAINED PHYSICIANS ABROAD: A CASE STUDY OF SASKATCHEWAN, CANADA

The purpose of the research is to explore the “Push” (Unfavourable conditions in country of origin) and “Pull” (Favourable conditions in destination country) factors that influenced your decision to migrate from Africa, how you integrated into your new working environment, the barriers that you faced in integrating and how these could affect future migration and retention in Saskatchewan.

Your effort in responding to this survey is greatly appreciated.

1.0. Personal information

Please check applicable answers for each of the following questions

1. Age:
 - a. > 30 ☐
 - b. 30-44 ☐
 - c. 45-64 ☐
 - d. 65+ ☐
2. Sex:
 - a. Male ☐
 - b. Female ☐
3. a. Country of birth:.....
b. Country of original citizenship:.....
4. Family status:
 - a. Single ☐
 - b. Married/with partner ☐
 - c. Widowed ☐
 - d. Divorced ☐
 - e. Other.....
5. Do you have children?
 - a. Yes ☐
 - b. No ☐If yes, are they
 - a. Living at home ☐
 - b. No longer living at home ☐
 - c. In Africa ☐
6. Year of immigration to

- a. Canada.....
- b. Saskatchewan.....

1.2 Medical Specialization

8. Field of medical specialization?

a. Family medicine/general practice ☐

b. Specialist (Please specify the field (e.g. Surgery, public health)

.....

9. Current position:

a. Family practice ☐

b. Specialist practice ☐

c. Public health/policy ☐

d. Administration ☐

e. Teaching ☐

f. Retired/ Inactive ☐

g. Others (please specify)

.....

2.0 Migration to Saskatchewan

10. Which of the following was your channel of recruitment to Saskatchewan?

a. Job fairs ☐

b. Recruitment agencies ☐

c. Advert on internet and professional journals ☐

d. Through word of mouth from a Family member or friend ☐

e. Overseas professional associations and support network ☐

f. Saskatchewan nominee programme or immigration point program. ☐

g. Personal research/initiative ☐

g. Others (please specify)

.....

.....

11. Please indicate the countries in which you have lived and/or practiced up to and including your arrival in Saskatchewan. Include provinces other than Saskatchewan where you lived and practiced.

	Country in which you practiced (or province in Canada)	Years of residence	Were you engaged in professional medical practice in these areas?
1.			
2.			
3.			
4.			
5.			

2.1 Push-pull factors

For questions 12-17, please check all applicable answers, using two check marks for primary reasons and one check mark for secondary reasons for migrating.

12. Which of the following, and other push factors in the healthcare system influenced your decision to leave your country?

- a. None-no professional push factors ☐
- b. (i) Lack of job satisfaction ☐
 - (ii) Work associated risk ☐
 - (iii) Lack of professional development opportunities ☐
 - (iv) Working conditions-e.g. scarcity of drugs and equipment ☐
- c. Others (please specify):

.....

.....

13. Which of the following, and other personal/social push factors influenced your decision to leave your country?

- a. None-no personal/social push factors ☐
- b. (i) Quality of life and crime ☐
 - (ii) War, civil conflict and political repression ☐
 - (iii) Lack of educational opportunities for self and children ☐
 - (iv) Lack of opportunities for spouse/partner ☐
- c. Others (please specify)

.....

.....

14. Which of the following, and other professional pull factors attracted you to Saskatchewan?

- a. None-no professional pull factors ☐
- b. (i) Higher rates of remuneration ☐
 - (ii) More satisfying work conditions ☐
 - (iii) A safe working environment ☐
 - (iv) Career development opportunities ☐
- c. Others (please specify)

.....
.....
15. Which of the following, and other personal/social pull factors influenced your decision to come to Saskatchewan?

- a. None-no personal/social pull factors ☐
- b. (i) High quality of life ☐
(ii) Freedom of speech and political prosecution ☐
(iii) Educational opportunities for children ☐
- c. Others (please specify)

.....
.....
16. Did you have a social network in Saskatchewan prior to arriving in the province? If so what was the nature of that network

- a. No social network ☐
- b. (i) Family/relatives ☐
(ii) Professional acquaintances ☐
(iii) Knowledge of a community of people from your country in Saskatchewan ☐
- c. Others (please specify)

.....
.....
17. Which of the following barriers did you have to overcome in order to migrate to Saskatchewan?

- a. Cost of re-qualification ☐
- b. Differential clinical practices ☐
- c. Time consuming immigration process ☐
- d. Search for position ☐
- e. moving cost for self and family ☐
- f. Professional obligation in home country ☐
- h. Family obligation in home country ☐
- d. Others (please specify)

2.2 Migration within Saskatchewan after arrival

18. Please indicate the places you have lived or practiced in after arriving in Saskatchewan in order of residence. Include location of practice, duration and reasons for migrating.

	Location	Duration(year)	Reasons for migrating
1.			
2.			
3.			
4.			
5.			

3.0 Issues of Integration

Questions 19-23 refer to your initial period of professional integration (approximately first 2 years in Saskatchewan)

Please check where applicable.

19. How would you characterise your initial professional/ social integration in Saskatchewan?

- a. Very easy/excellent ☐
- b. Easy/good ☐
- c. Somewhat easy/ somewhat difficult ☐
- d. Difficult ☐
- d. Very difficult ☐

Comments

.....

20. How important were each of the following factors in your initial professional integration in Saskatchewan?

- | | Important <input type="checkbox"/> | Somewhat important <input type="checkbox"/> | Unimportant <input type="checkbox"/> |
|---|------------------------------------|---|--------------------------------------|
| a. Difficulties with licensing procedure. | | | |
| b. Relations with you patients. | „ <input type="checkbox"/> | „ <input type="checkbox"/> | „ <input type="checkbox"/> |
| c. Medicare system. | „ <input type="checkbox"/> | „ <input type="checkbox"/> | „ <input type="checkbox"/> |
| d. Access to hospital privileges. | „ <input type="checkbox"/> | „ <input type="checkbox"/> | „ <input type="checkbox"/> |
| e. Inadequate infrastructure. | „ <input type="checkbox"/> | „ <input type="checkbox"/> | „ <input type="checkbox"/> |
| f. Opportunities for promotion/ mobility. | „ <input type="checkbox"/> | „ <input type="checkbox"/> | „ <input type="checkbox"/> |
| g. Others (please specify) | | | |

.....

21. How relevant was your medical training from Africa to your practice in Saskatchewan?

- a. Very relevant/relevant ☐
- b. Relevant ☐
- b. Somewhat relevant/somewhat irrelevant ☐
- c. Irrelevant ☐
- d. Very irrelevant ☐

Comments

.....
.....
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22. How helpful were your colleagues (fellow health care workers) with your integration into the work environment? (Please check all that apply)

- a. Very helpful ☐
- b. helpful ☐
- c. Some were helpful/others not helpful ☐
- e. Unhelpful ☐
- f. Very unhelpful ☐

Comments

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23. Did you find any of the following an issue which affected the response of patients with whom you interacted?

- a. Accent ☐
- b. Origin ☐
- c. Race ☐
- d. Gender ☐

e. Other (please specify).....

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Comments on patient response

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3.1 Initial Personal /social integration (approximately first 2 years in Saskatchewan)

24. How important were the following factors in your initial personal/social integration?

- | | Important | | Somewhat important | | Unimportant | |
|---------------------------------|----------------------------|--|----------------------------|--|----------------------------|--|
| a. Weather. | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| b. Food. | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| c. Community services. | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| d. Community welcome. | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| e. Recreation | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| f. Safe environment | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| g. Worship | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| h. Others (please specify)..... | | | | | | |

25. If applicable, how important were the following factors in the initial personal/social integration of your spouse or partner?

- | | Important | | Somewhat important | | Unimportant | |
|--------------------------------|----------------------------|--|----------------------------|--|----------------------------|--|
| a. None-no spouse or partner | <input type="checkbox"/> | | | | | |
| b. (i) Food. | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (ii) Weather. | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (iii) Access to transportation | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (iv) Employment for spouse | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (v) Community services | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (vi) Community welcome | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (vii) Safe environment | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (viii) Recreation | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (ix) Worship | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | | „ <input type="checkbox"/> | |
| (c) Others (please specify) | | | | | | |

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Comments.....

26. Factors which posed initial challenges in the personal/social integration of your children

a. None-no children ☐

	Important	<input type="checkbox"/>	Somewhat important	<input type="checkbox"/>	Unimportant	<input type="checkbox"/>
b. (i) Weather.						
(ii). Food	„	<input type="checkbox"/>	„	<input type="checkbox"/>	„	<input type="checkbox"/>
(iii). Recreation	„	<input type="checkbox"/>	„	<input type="checkbox"/>	„	<input type="checkbox"/>
(iv). Access to good education.	„	<input type="checkbox"/>	„	<input type="checkbox"/>	„	<input type="checkbox"/>
(v) Community services	„	<input type="checkbox"/>	„	<input type="checkbox"/>	„	<input type="checkbox"/>
(vi). Community welcome	„	<input type="checkbox"/>	„	<input type="checkbox"/>	„	<input type="checkbox"/>
(vii). Safe environment	„	<input type="checkbox"/>	„	<input type="checkbox"/>	„	<input type="checkbox"/>

c. Others

.....

Comments.....

27. How would you characterize your *professional integration* now?

- a. Very comfortable ☐
- b. Comfortable ☐
- c. Somewhat comfortable/somewhat uncomfortable ☐
- d. Uncomfortable ☐
- e. Very uncomfortable ☐

Comments

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3.2 Long-term integration/plans

28. How would you characterize your *personal/social integration* now?

- a. Very comfortable ☐
- b. Comfortable ☐
- b. Somewhat comfortable/somewhat uncomfortable ☐
- c. Uncomfortable ☐
- d. Very uncomfortable ☐

Comments.....
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29. Do you plan to live in your current location for the next few years?

- a. Yes ☐
- b. No ☐
- c. Uncertain ☐

Comments.....
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If your answer was “YES” to question 29, which of the following factors would influence your decision to stay in Saskatchewan? (Use two check marks for the most important and one check mark for others that apply)

- a. New social and cultural bonds ☐
- b. Local/new lifestyle patterns ☐
- c. Risk of disruption to family life and education of children ☐
- d. Lack of information on job opportunities back home ☐
- e. Deterioration of health system back home ☐
- f. Others (please specify)

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30. Do you plan to move to a different town in Saskatchewan?

- a. Yes ☐
- b. No ☐

c. Uncertain ☐

If yes, what kind of community do you hope to move to?

a. Regina/Saskatoon ☐

b. A medium size city (8,000-40,000) ☐

c. A smaller community ☐

Comments.....
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31. Do you hope to move to a different province of Canada?

a. Yes ☐

b. No ☐

c. Uncertain ☐

If yes which province do you hope to move to?

a. Ontario ☐

b. Alberta ☐

c. British Columbia ☐

d. Others (Please specify)

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Comments.....
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32. Do you hope to move to the United States, United Kingdom or Europe?

a. Yes ☐

b. No ☐

c. Uncertain ☐

If yes, what is your preferred
destination.....

Comments

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33. Do you plan to go back to Africa?

a. Yes ☐

b. No ☐

c. Uncertain ☐

If yes, where would you like to go back to?

a. Country of origin ☐

b. Another country ☐

If so, please

specify.....

Comments

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34. Which of the following factors would influence your decision to return to your country of origin? (Use two check marks for the most important and one check mark for others that apply)

a. High level morale ☐

b. Rewards and incentives ☐

c. Social and kinship ties ☐

d. Improvements in the healthcare system ☐

e. Political reform ☐

f. Others (please specify)

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Thanks for your cooperation in responding to this survey

I would like to conduct follow-up interviews to better understand the circumstances that led to physicians migration and integration into the health care system in Saskatchewan. Please understand that, not all people who consent to have a follow-up interview will be contacted or interviewed.

If you would be willing to participate in a follow-up interview, please sign below and provide contact details. Your assistance is greatly appreciated

Consent to be contacted for a follow-up interview.

.....

Signature

Date

Contact details.

Name.....

Phone
number.....

Email
address.....

Office/home address

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APPENDIX D: INTERVIEW GUIDE FOR PRACTICING AFRICAN-TRAINED PHYSICIANS.

Preamble

I am Seraphine Kogo, a graduate student enrolled in the MA program in the Department of Geography at the University of Saskatchewan. Before I came to Saskatchewan, I studied for my Bachelor of Arts degree in Geography and Sociology at the University of Ghana. Coming from Africa, I have witnessed the impacts physician migration has on the healthcare system especially in rural areas. Now in Saskatchewan, I am interested in studying the circumstances leading to African-trained physician migration and their experiences with integrating into the destination country. Results from this research will form the basis of my MA thesis.

The purpose of my research is to explore the “Push-Pull” factors that influenced your decision to migrate from Africa, how you integrated into your new working environment, the barriers that you faced in integrating and how these could affect future migration and retention in Saskatchewan.

Your effort in responding to this interview is greatly appreciated. You have the opportunity to decline to answer any question if it causes distress or for any other reason. You could also withdraw your consent to participate in this interview at any time.

1. Could you please tell me more about yourself,
 - a. Which country you got your medical education
 - b. Where you practiced after your medical degree
 - c. Your migration to Saskatchewan?

2.0 Circumstances leading to migration

2.1 Push/pull factors

2. Tell me more about what led to your migration to Saskatchewan?
 - (i) Did your professional or personal objectives influence your decisions to migrate to Saskatchewan?
3. What was the political and economic situation in your country at the time?
4. Did that influence your decision to migrate?
5. How were working conditions back at home?
6. Was the decision to migrate a difficult decision considering you had to leave family and friends behind?
7. What were some of the barriers you had to overcome before migrating?
8. How did you get information about job opportunities here?
9. Did you have a family member, friends or know about a large community of people from your country here? Did they provide you with information about job opportunities in Saskatchewan?

3.0 Issues of integration

3.1. Professional integration (approximately first 2 years in Saskatchewan)

10. Could you tell me about some of your initial challenges of getting into the healthcare system in Saskatchewan?
11. How difficult or easy was it like obtaining a license to practice?
12. Could you talk a little more about your initial challenges in the health system?
13. Did race, accent, gender or origin an issue interacting with colleague workers?
14. What were some of the programs to help you understand some of the practices in the health system here?
15. How helpful were your colleague workers?
16. How relevant or irrelevant was your medical training from Africa to your practice in Saskatchewan?
17. What was your first encounter with your patients like?
18. Did race, accent, gender or origin an issue in your interactions with your patients?
19. How helpful or unhelpful was your social network prior to you emigration to Saskatchewan?

3.2. Personal/social integration (approximately first 2 years in Saskatchewan)

20. Apart from your initial challenges of getting into the health care system, could you tell me about some of the initial social/personal challenges of integration?
22. How challenging was it for you family in adapting to the environment and society
23. Where there programs to help you and your family integrate into the community?
24. How helpful were your home community and the people in the community in helping you and your family integrate into the society?

4.0 Satisfaction/plans for the future

25. Do you feel more satisfied practicing in Saskatchewan?
26. What recommendations do you have to make physicians more satisfied with their profession and stable in Saskatchewan?
27. What are some of your possible retirement plans?
 - a. Do you have any plans to retire home?

APPENDIX E: A BREAKDOWN OF DATA COLLECTION METHODS BY REGION OF ORIGIN AND LOCATION OF PRACTICE

Activities	South Africa			North Africa			Others			Totals
	Urban	Medium	Rural	Urban	Medium	Rural	Urban	Medium	Rural	
Number contacted (phone, faxes, letters)	22	16	13	17	14	2	21	9	10	124
Number of yes's	7	6	6	5	2	-	9	6	3	44
Number of no's	4	3	-	1	2	1	1	-	-	12
Number of questionnaires sent out	7	6	6	5	2	-	9	6	3	44
Number of questionnaires returned	6	3	4	4	2	-	5	7	2	33
Number who wanted a follow up interview	2	3	3	2	1	-	3	3	-	17
Interviews Conducted	1	2	2	-	1	-	3	2	-	11